Vol. 14 No. 1
January, 1965

Maryland
STATE MEDICAL JOURNAL

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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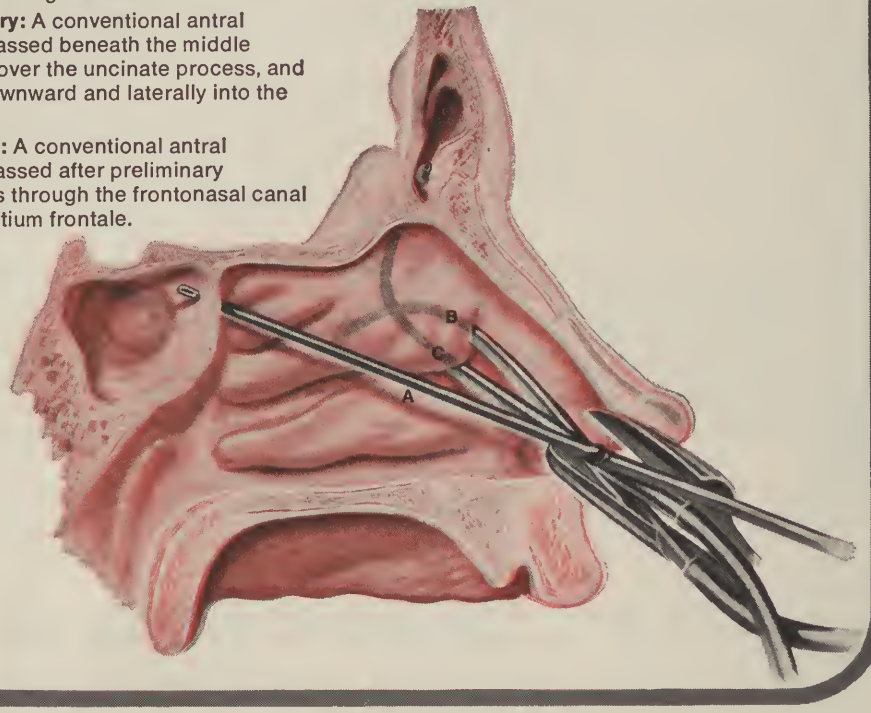
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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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Reception 5:30 PM Dinner 6:30 PM

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MARYLAND ASSOCIATION FOR MENTAL HEALTH

Februory 2—7:30 PM—1211 Cathedral Street, Baltimore

"The Estimotion of Anesthetic Risk," Arthur S. Keots, MD, professor and chairman, Boylor University College of Medicine.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

February 5—8:30 PM—1211 Cothedral Street, Boltimore

"Toking o Trip Through the Alimentary Canal," moderated by Somuel Morrison, MD. Ten speokers will present 10-minute topics in gastroenterology. Acceptoble for two hours Cotegory I credit by the AAGP

BALTIMORE CITY MEDICAL SOCIETY

February 11—8:30 PM—1211 Cothedrol Street, Baltimore

"Early Greek Concepts on Mind ond Insanity," Ralph Koufmon, MD, New York City.

MARYLAND PSYCHIATRIC SOCIETY

Februory 17—8:00 PM—1211 Cathedrol Street, Baltimore

"Outpotient ond Home Rehabilitation" 1) of the cardiac potient, Fronk Borges, MD; 2) of the elderly patient, Edith Schoenrich, MD; 3) of the dermatologicol patient, Horry Robinson, MD; 4) of the stroke patient, Florence Mahoney, MD.

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February 18-19—Marriott Motor Motel, Philodelphia

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January 31—Anti-Smoking Progrom

Februory 7—Fertility ond Sterility

February 14—Birth Defects

February 21—X-Roy, Whot It Shows

Februory 28—Nuclear Medicine

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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card. Patient's numbering assignments are controlled by these file cards. When a patient comes for a treatment, his ledger card is removed from the file; the aide enters the date, doctor's number, and patient's first name on the card and attaches it to the medical history file. When a treatment is completed, the doctor or nurse enters the service code number for the treatment rendered, along with the correct charge. This type of simple entry takes only a few seconds and there are no additions, subtractions, or balances to carry forward. When the patient pays his account this is also entered on the ledger card as received at the office. A doctor may continue to use his present receipt system for cash payments.

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Automation billing offers immediate financial answers along with complete records not only on the doctor's patients but on many other phases of bookkeeping. The MEDAC system prepares and mails to the doctor a daily cash receipts and charges report; a detailed monthly aging of patient accounts is furnished, together with a billing and collections analysis.

Further advantages of MEDAC include vendor ledger cards containing a complete record of purchases from a particular vendor. Employee ledger cards record all needed information for employee payrolls, including gross pay, net pay, federal income tax withheld, Social Security tax withheld, and other deductions. There are also travel and entertainment cards to answer the questions of who, why, and where, now so important in determining whether or not the expense is tax deductible. Here, too, MEDAC furnishes and

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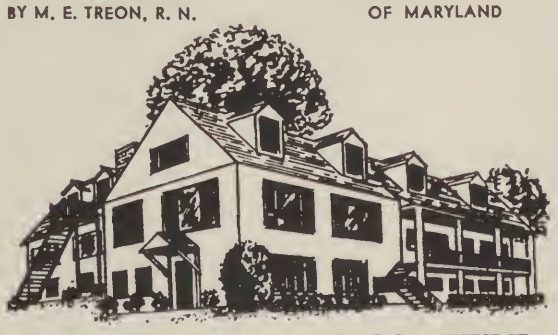
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Mrs. Shelton has had many years of experience in the care of the aged, and under her supervision the home has achieved a fine reputation. Mrs. Shelton's experience includes 10 years of geriatric nursing. Before joining the MONTGOMERY CONVALESCENT HOSPITAL, INC. staff, she was affiliated with Resnor Hospital in Bethesda. William H. Ferguson, MD, is the director and president of the corporation, and Mr. and Mrs. George W. Treon are also officers of the corporation.

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PLAN NOW-

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APRIL 21, 2

The Alcaza

Wednesday, April 21

Morning

House of Delegates Meeting

Afternoon

Discussion of Health Evaluation Tests

Finney Lecture
to be announced

Trimble Lecture
to be announced

David C. Sabiston, Jr., MD
Duke University
"The Diagnosis and Treatment of Pulmonary Embolism"

Evening

Medicolegal Symposium
subject to be announced

Thursday

Morning

E. Perry McCullagh, MD
Cleveland Clinic, Ohio
"Recent Studies in Hypopituitarism"

George S. Mirick, MD
Health Research Council, New York
"Viral Hepatitis"

Carl Muschenheim, MD
Cornell University
"The Treatment of Respiratory Insufficiency"

ROUND TABLE LUNCHEON

Afternoon

Lee Ramsay Straub, MD
Cornell University
"The Rheumatoid Hand"

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Afternoon, continued

eodore R. Fetter, MD
Jefferson Medical College
"Urological Problems in General Practice"

chard W. TeLinde, MD
e Johns Hopkins University
"Carcinoma-in-situ of the Cervix: Our Present Views on Diagnosis and Treatment"

Evening

ECEPTION AND PRESIDENTIAL DINNER

Something new in entertainment!

Friday, April 23

Morning

Thomas B. Connor, MD
University of Maryland
and
R. Patterson Russell, MD
The Johns Hopkins University
"The Diagnosis and Treatment of Hypertensive States"

Thomas W. Mattingly, MD
George Washington University
"Effect of Aging on Diagnosis and Treatment of Heart Disease"

John H. Talbott, MD
Editor, Journal of the American Medical Association
"Gout: A Diagnostic and Therapeutic Challenge"

Afternoon

House of Delegates Meeting

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APRIL 21, 22, 23, 1965 BALTIMORE, MARYLAND

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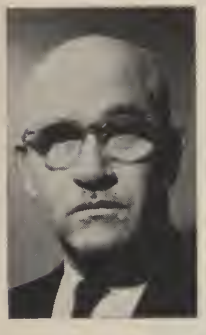
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Date of arrival .....Date of departure .....

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Thomas W. Mattingly, MD, will give the third annual Jesse C. Coggins Lecture on Geriatrics. His subject will be "Effect of Aging on Diagnosis and Treatment of Heart Disease." Dr. Mattingly is clinical professor of medicine at both George Washington University School of Medicine and Georgetown University School of Medicine, and lecturer in cardiovascular diseases, School of Cardiovascular Nursing, Catholic University. Dr. Mattingly was born in Marbury, Md., received his medical degree at Georgetown University School of Medicine, and did graduate work at Harvard Medical School and Washington University School of Medicine, St. Louis. He served in the U. S. Army in grades from 1st lieutenant to brigadier general and, at his own request, retired in 1958 after 30 years of service.



Dr. Mattingly is chairman, Department of Medicine and chief of Cardiovascular Section at the Washington Hospital Center. He is consultant in cardiology at the Walter Reed General Hospital; consultant to Armed Forces Institute of Pathology, cardiovascular section; consultant at the Holy Cross Hospital; and consultant in cardiology at the Children's Hospital in Washington. He was consultant to the White House physician from 1950 to 1958.

Among the many awards which Dr. Mattingly has received are the Bronze Star Medal and the Legion of Merit. The latter was for exceptionally meritorious service as cardiologist, Walter Reed Hospital, 1950 to 1958.

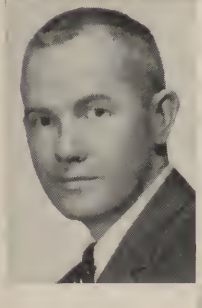
He holds offices in numerous local and national organizations and is certified by the American Board of Internal Medicine and the Subspecialty Board, Cardiovascular Diseases.

"The Rheumatoid Hand" will be the subject of the paper presented by **Lee Ramsay Straub, MD,** of New York. Dr. Straub received his degree of MDCM at McGill University and served internships at Shriner's Hospital for Crippled Children in Montreal and at the Wisconsin General Hospital. He was a resident and a fellow in orthopedic surgery at the Hospital for Special Surgery in New York.



Dr. Straub's major scientific interest is musculoskeletal disease. Five of his outstanding publications are:

The Results of Epiphysiodesis and Femoral Shortening in Relation to Equalization of Limb Length
Lumbosacral Fusion with Metallic Plate Fixation
A Clinical Evaluation of Tendon Transplantation in the Paralytic Foot
Surgery of the Arthritic Hand
The Surgery of Gout in the Upper Extremity.





Thomas B. Connor, MD, and **R. Patterson Russell, MD,** will jointly present the Harvey Grant Beck Memorial Lecture on "The Diagnosis and Treatment of Hypertensive States."

Dr. Connor, a native Baltimorean, attended Loyola College and received his MD degree from the University of Maryland School of Medicine. He served an internship and residency at the Mercy Hospital in Baltimore and was a fellow in medicine (endocrine and metabolic diseases under John Eager Howard, MD) at The Johns Hopkins Hospital. Between 1951 and 1959, Dr. Connor was assistant professor of medicine and director of the Division of Endocrinology and Metabolism, University of Maryland School of Medicine, and assistant physician, Outpatient Department, The Johns Hopkins Hospital. Currently, he is associate professor of medicine and director, Division of Endocrinology and Metabolism, University of Maryland School of Medicine, and director, Clinical Study Center, University Hospital. Calcium metabolism, metabolic bone disease, and renal hypertension are Dr. Connor's research interests.

Dr. Russell received his AB degree at Princeton University and his MD degree at The Johns Hopkins University School of Medicine. He was an intern and assistant resident on the Osler Medical Service at The Johns Hopkins Hospital. This was followed by USPHS fellowships at the National Heart Institute and a residency on private medical service at Hopkins. At present, Dr. Russell is instructor in medicine, The Johns Hopkins University School of Medicine; and associate physician-in-charge, Moore Clinic (hypertension), The Johns Hopkins Hospital.

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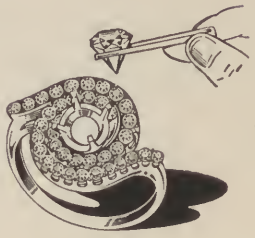
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EXECUTIVE SECRETARY'S NEWSLETTER

January, 1965

RESOLUTIONS

Resolutions, in order to be considered at the Faculty's Annual Meeting in April, 1965, must be in the Faculty office by FEBRUARY 24, 1965.

The Reference Committee meeting has been scheduled for:

THURSDAY, MARCH 25

at 8:00 p.m., in the Faculty Building.

All members are invited to attend and express their feelings on any matters scheduled to come before the Reference Committee hearing.

Resolutions received at the time of this writing include:

1A/65 - Incorporation for Professional Persons (Wicomico County Medical Society)

2A/65 - Inclusion of Physicians on a Voluntary Basis under the Social Security System (George Vash, M.D.)

3A/65 - Return of Grant of the Tobacco Industry by the AMA (George Vash, M.D.)

Full details of resolutions and other pertinent data will be mailed in the near future to all Component Societies. Individual physician-members interested in any of the above resolutions may obtain them through the Faculty Office.

PRESIDENTIAL DINNER

The Presidential Dinner this year will be held on Thursday, April 22. The speaker will be announced at a later date.

HOTEL RESERVATIONS

In connection with the Annual Meeting, April 21, 22, and 23, a block of 50 rooms has been

reserved for the Faculty at the Sheraton-Belvedere. You should mention the Faculty's name when making your reservation.

ANNAPOLIS LEGISLATIVE ASSEMBLY

The Annapolis Legislative Assembly will convene on January 20 for a 70-day session. As has been the custom in the past, the Faculty will sponsor, in cooperation with the Anne Arundel Medical Society, the Anne Arundel Health Department and the Anne Arundel Hospital, a first aid room in the General Assembly.

As instructed by the House of Delegates, full-time representation in Annapolis will be effected this year.

Any member of the Faculty wishing to make contact with the Faculty representative in Annapolis may do so through the First Aid Room.

TED CHILCOAT LEAVES FACULTY

Mr. Theodore R. Chilcoat, Jr., Assistant Executive Secretary of the Faculty, left on December 31 to become a field representative of the American Medical Association. Mr. Chilcoat will cover the States of Connecticut, Massachusetts, Rhode Island, New Jersey, and Delaware.

The best wishes of the Faculty members and staff go to Mr. Chilcoat on this change in post.

NEWS NOTES

William E. Peterson, M.D., and David D. Golub, M.D., announce the continuation of Radiological practice at 201 W. Madison St., Baltimore.

Richard D. Richards, M.D., has been named Associate Director of the Eye Research Foundation of Bethesda. Dr. Richards is head of the Department of Ophthalmology at the University of Maryland School of Medicine.

New officers of the Maryland Dermatological Society are: William Dvorine, M.D., President; and Bahram Sina, M.D., Secretary.

John M. Sargeant

Executive Secretary

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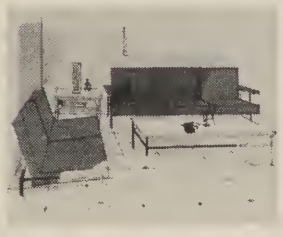
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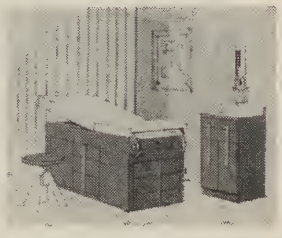
SAratoga 7-7333

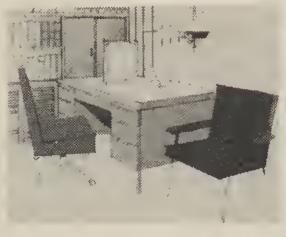
Serving the medical profession for 45 years

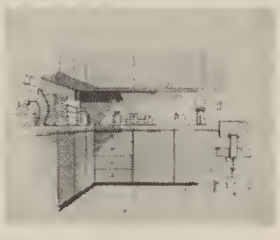


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Phenacetin	150 mg.
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To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

Also available with codeine—on prescription only—as **'EMPRAZIL-C'®** tablets

Complete literature available on request from Professional Services Dept. PML.

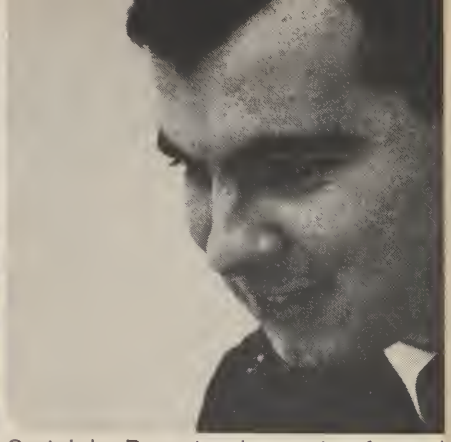
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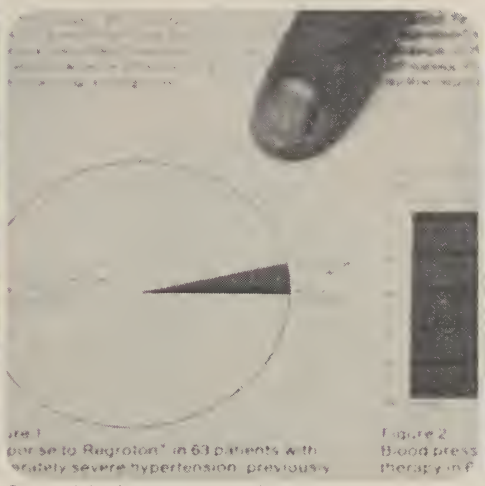
Not *another* reserpine-diuretic combination!



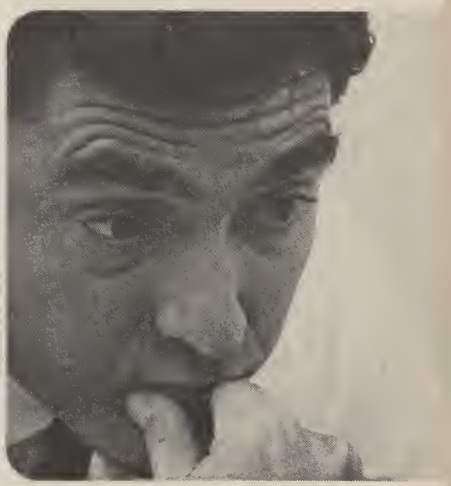
Certainly. Regroton has outperformed other combinations.



/ho?



Says this 2-year study by Finnerty.



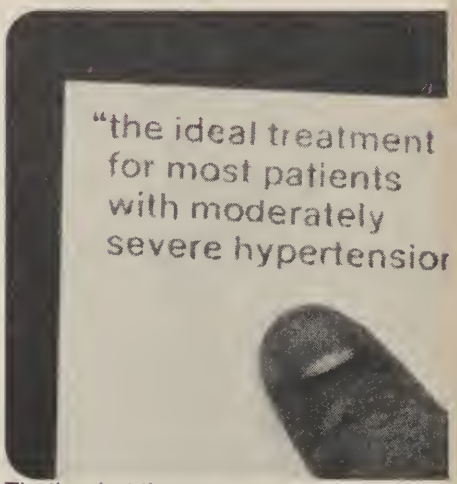
What's the dosage?



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ndications: History of mental depression, nsitivity, and most cases of severe renal tic diseases.
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ions: Reduce dosage of concomitant anti-nsive agents by one-half. Discontinue if N rises or liver dysfunction is aggravated. yte imbalance and potassium depletion cur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal June 14—19, 1964.

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1. Griffith, R. S., and Black, H. R.: Current Ther. Res., *6*:253, 1964.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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Maryland State Medical Journal
Vol. 14, No. 1
January, 1965

Editorial

HAVE YOU RETURNED YOUR READERSHIP QUESTIONNAIRE?

IF YOU HAVE, THANK YOU.

If you haven't, won't you please do it now. The information you can supply is of the utmost importance to us, and ultimately to you.

The questionnaire was mailed to you a month ago. The accompanying letter points out the ways in which your response will help us, and these bear re-emphasis:

1. It will enable us to ascertain what is most interesting—and least interesting—to the majority of our readers.

2. It will enable us to produce a better journal, with the types of articles, both scientific and non-scientific, that our readers want.

3. It will enable us to evaluate the JOURNAL'S importance and effectiveness in bringing information of value to you.

4. It will enable our advertisers to judge the effectiveness of carrying their messages to the busy physician, not only concerning new and current drug products but also about services and products for your professional and personal use.

We know you are busy, but the questionnaire is short and requires only brief answers. An addressed, postage-paid envelope has been included for your convenience. If you still don't have time to complete the questionnaire, please return it to us anyway to let us know you are interested.

1965



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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, SEPTEMBER 24

1. Several osteopaths were present to discuss proposed changes in the Maryland osteopathic law. They left with the understanding that they would submit some proposed revisions in the law which would provide for osteopathic representation on the Board of Medical Examiners, which would then have to be decided upon by the Council.

2. Approval was given to submitting the name of the Maryland Diabetes Association as a candidate for the annual organization achievement award of the Health and Welfare Council of Baltimore Area, Inc. This nomination is in recognition of its operation of Camp Med-Chi for diabetic children.

EXECUTIVE COMMITTEE, OCTOBER 8

1. Appointments were made to the Blue Cross Physicians Review Panels.

2. A request from the Maryland Diabetes Association for joint use of the Faculty name and seal on a pamphlet devoted to diabetes detection was disapproved because of the danger of establishing a precedent.

3. A request from the Faculty for funds to help defray the cost of all-day open-house tours of mental health facilities in the state was disapproved.

4. Appointments were made to the Advisory Council on Mental Hygiene.

5. In a joint session with the Hospital Council Executive Committee, the seven recommendations of the Gruehn Committee were discussed and are to be summarized and presented in a letter to be signed by the presidents of both groups. Clarification is to be obtained on the following recommendation.

4. Reduction in the costs of physician work done in the hospital

Adaptation to present-day conditions requires reconsideration of (a) relationships under which physicians can be compensated as employees of the hospital when they perform or supervise certain phases of patient-care work within the hospital, (b) relationships which should exist between the medical schools and the various individual hospitals of the state in respect to the use and further training of graduate students, and (c) methods which should produce less costly ways of administering equally good educational programs than the present ones.

6. In the matter of Faculty Resolution 1A/64, it was agreed that the intent of this resolution had been accomplished and it was not necessary to take any further action.

7. A summary of legislative activity planned for 1965 was presented. It was agreed that staff personnel will continue to pursue these items on a mutual basis.

EXECUTIVE COMMITTEE, OCTOBER 29

1. Attendance of a staff member at the Professional Convention Management Association and Medical Exhibitors Association meetings was approved.

2. The regular staff Christmas party was approved.

3. Early closing before Christmas and New

Year was left to the discretion of the Executive Secretary.

4. Appointment of Edgar P. Williamson, 2nd, MD, to the Advisory Council on Mental Hygiene was approved.

5. Approval was given to inviting the new State Health Officer to attend the first Council meeting after his assumption of the post.

6. An appropriate wire signed by the Faculty President is to be sent to the retiring State Health Officer on the occasion of the November 5 testimonial dinner in his honor.

7. A ruling from the Board of Medical Examiners concerning administration of intravenous injections by nurses was referred to the Liaison Committee.

8. The proposed changes in the licensing of osteopaths is to be referred to an ad hoc committee composed of medical school representatives and Executive Committee members, with the chairman to be named by the Council chairman. This committee should then report to the Council and probably the House of Delegates when conclusions are reached.

9. The proposed Baltimore City earnings tax was deemed to be a matter for individual physicians to protest or support as they wish.

10. Approval was given for Faculty participation in discussions in regard to formation of a voluntary planning agency for areawide health facilities.

11. An offer regarding the availability of a Baltimore-born physician's portrait for 1,000 guineas was declined.

12. Executive Committee expressed disapproval and concern over the use of Faculty's addressograph plates for mailing a political pamphlet. The physician who did this, without the Faculty's knowl-

in the overweight stable adu

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



edge, is to be notified of this disapproval. Hereafter, all requests for addressing must be accompanied by a sample of the material to be mailed, thus ensuring the legality and suitability of the mailing.

COUNCIL, NOVEMBER 19

1. Physicians Defense was ratified for members requesting it. An appeal against Council's denial of Physicians Defense in one case was considered and again denied.

2. Termination of a case was reported.

3. Council meeting dates for 1965 were approved.

4. Purchase of the AMA film on medicine and religion, entitled "The One Who Heals," was authorized.

5. Purchase of libel and slander coverage in amounts of $100,000/$300,000 for officers and committeemen was approved. This will be added to the Faculty's comprehensive liability policy.

6. Closing of the library for use by members during Board examinations was approved.

7. A report was made on activity planned for the 1965 session of the state legislature.

8. Correspondence regarding Blue Cross decision with respect to the proposed Physicians and Surgeons Hospital in Annapolis was read. The Faculty has already made known its opinion to Blue Cross. The correspondent is to be advised of the Faculty's concern as well as of appropriate actions of the Executive Committee and Council.

9. No further cigarette advertising is to be accepted by the *Journal* upon completion of present contracts.

10. A mailing soliciting opinion from

diabetic

.DBI lowers high blood
ugars without promoting
at synthesis, encourages
radual weight loss[2-9]



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DBI promotes glucose utilization via the physiologic Embden-Meyerhof pathway.. reduces high blood sugars, lowers toward normal elevated blood insulin levels, encour ages gradual weight reduction. For the ketoacidosis-prone diabetic, however, insuli is still the essential hypoglycemic agent.

side effects: Gastrointestinal, occurring more often at higher dosage levels, abate promptl upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) whicl must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, anc treated accordingly. Lactic acidosis has been reported in non-diabetics and diabetics treatec with insulin, with diet, and with DBI. Question has arisen regarding possible contributio of DBI to lactic acidosis in patients with renal impairment and azotemia and also those wit severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determina tions should be made when DBI is administered in the presence of chronic renal disease DBI should not be used when there is significant azotemia. Any cardiovascular lesion tha could result in severe or sustained hypotension, which may itself lead to development of lacti acidosis, should be considered cause for immediate discontinuation of DBI at least unti normal blood pressure has been restored and is maintained without vasopressors. Shoulc lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease wit uremia, cardiovascular collapse. Not recommended without insulin in acute complications o diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Gordon, E.S.: Metabolism 11:819, 1962. 2. Grodsky, G.M. et al.: Metabolism 12:278, 1963 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H.S.: Metabolism 12:333, 1963 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. anc Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J.M. et al.: Med. Times, July 1964.

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the membership regarding a post-convention cruise in conjunction with the 1966 Annual Meeting was approved.

11. Emeritus membership is to be recommended for Emmett L. Jones, MD, Allegany County; Royal A. Bell, MD, Washington County; and Henry F. Graff, MD, Washington County.

12. Sponsorship of a seminar on nutrition, to be held March 18, 1965, was approved.

13. Announcement was made that Theodore Chilcoat had resigned to accept a position as an AMA field representative, effective December 31, and that Richard Nelson will replace Harry Hinton as the AMA field representative in Maryland. A unanimous vote of appreciation was accorded both Mr. Chilcoat and Mr. Hinton for their services to the medical profession in Maryland.



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RESOLUTIONS

Important Notice for Component Medical Societies and Individual Members of Medical and Chirurgical Faculty

All resolutions or recommendations for presentation to the House of Delegates must be in the Faculty Office by WEDNESDAY, FEBRUARY 24, 1965, which is eight (8) weeks prior to the Annual Meeting, April 21, 22, 23, 1965. This is referred to in the following quote from the Faculty Bylaws:

. . . A Reference Committee of five members of the House of Delegates to which all Resolutions involving questions of Faculty policy, except those proposed by the Council or committees of the Faculty, shall be referred at least eight weeks prior to any regular session . . . of the House of Delegates. All such resolutions shall be reported to the House of Delegates with the committee's recommendations, provided that, with the sponsor's approval, the committee may revise any resolution.

The meeting of the Reference Committee is open to all members of the Faculty in good standing, who may attend and express their opinions. Notice of the date and place of the Committee meeting will be sent to all members.

RESOLUTIONS for April, 1965, House of Delegates must be in the Faculty Office by WEDNESDAY, FEBRUARY 24, 1965

In a preliminary study, made during the first seven months of operating an anti-calory clinic, the authors found that patients using an amphetamine combination drug were able to lose twice as many pounds

USE OF AN AMPHETAMINE-COMBINATION DRUG IN AN ANTI-OBESITY CLINIC

as patients in the no-drug control group. The study was not an attempt to test an amphetamine-type drug but rather to compare the results of use of this adjunct with those from no medication in an outpatient clinic.

MERRILL I. BERMAN, MD
IAN R. ANDERSON, MD
Co-directors, Anti-Calory Clinic

There has been a great deal of interest in our growing waistline of late with the White House and its entourage advocating 50-mile hikes and the labeling of the previous decade as the "Flabby Fifties." The public has been deluged with diet fads and frauds. They have been told that "calories don't count," that starvation is the panacea for obesity, and they have been advised to eat unsaturated fats and all sorts of lurid concoctions.

A plethora of studies has been conducted on weight reduction and diet counseling both with and without anorexogenic drugs; however, most of the work has pointed out one uncompromising and unhappy fact: the majority of patients who lose weight will regain it within a year, and 40% will regain or exceed their previous weight even with intensive therapy.[6] In our clinic, which meets once a week for two hours, we have begun a long-range program to attempt once again to determine what unconscious psychological factors are paramount in the obese personality; what familial and genetic factors predominate, and what factors, if any, will be useful in determining which patients will lose weight with and without drugs, and who will lose only to regain in a relatively short time.

The patients in our clinic are given a complete medical examination, including blood chemistries such as fasting blood sugar, cephalin flocculation, bilirubin, thymol turbidity, A/G ratio, protein-bound iodine, as well as hemoglobin, hematocrit, leukocyte count, and differential. The psychological profile is determined by the Minnesota Multiphasic Personality Inventory (MMP),[11, 12, 18] the Cornell Medical Index,[13] and the Rosenzweig Picture-Frustration Study.[4, 17] Patients are also interviewed individually.

At the first meeting the patients are told:

1) The clinic is designed to help them lose one pound a week in the hope of keeping it off.
2) They will be encouraged to change their old eating habits, and only certain patients will be given medication, as a crutch, when necessary.
3) There is only one way to lose weight and that is to eat less than is needed to maintain normal activity. There are no miracle cures.

Each patient is asked to record his actual diet for one week. This diet is then reviewed with an eye for reducing excess starches and introducing as much protein as possible into the diet. Patients are encouraged to substitute fresh fruit and vegetables for the more fattening and less nutritious foods, and they are given a great deal of nutritional counseling.

At the first meeting a complete medical history

TABLE I

Group I				Group II			
Age	Begin. Weight	Weight at Ten Weeks	Pounds Lost	Age	Begin. Weight	Weight at Ten Weeks	Pounds Lost
40	273	249	26	49	181	177	4
25	278	253	25	40	163	153	10
37	184	159	26	33	185	172	13
49	217	207	11	49	139	135	4
49	144	135	9	40	174	165	9
48	225	210	15	42	252	237	15
36	214	196	18	27	265	253	12
29	211	165	26	27	220	209	11
31	214	198	16	50	213	194	19
30	218	194	24	40	158	156	2
41	155	137	18	46	195	190	5
40	164	130	34	36	165	154	11
37	197	178	19	35	240	224	16
47	167	149	18	30	155	147	8
38	193	175	18	46	210	209	1
47	174	154	20	28	138	131	7
38	165	150	15	38	252	251	1
35	239	224	15	35	239	222	17
29	158	144	14				
36	180	153	27				
36	199	176	23				
34	213	185	28				
40	155	138	17				
29	211	185	26				
34	321	303	18				

n_1=25 Av. age_1=37.4 Av. wt. $loss_1$=20.204 pounds
n_2=18 Av. age_2=38.333 Av. wt. $loss_2$=9.611 pounds

is taken, including family constellation (ie, who else is overweight, underweight, or normal weight in the family) and when the patient gained weight. They are asked for their weight now, 10 years ago, 20 years ago, and so on. They are also asked to tell why they wish to lose weight, how many pounds, and how fast. A review of prior weight reduction attempts is also outlined in each medical history.

We have processed more than 100 patients. We are reporting our results on the use of an amphetamine-type drug consisting of methamphetamine hydrochloride, methamphetamine saccharate, amphetamine sulphate, and dextro-amphetamine sulphate in equal proportions of 2.5 mg in 10 mg tablets (Obetrol). This drug was tested on one group of patients and compared with a similar clinic group on no medication. The final outcome of this study will await its ultimate re-evaluation when the patients are reviewed one year from the time they entered the clinic program. This will occur each time a group of patients reaches the one-year mark to determine whether or not they have maintained their weight loss. These results, as well as the summation and summarization of the psychological and biochemical data, will be presented in subsequent papers.

Patients were selected at random from our clinic population. This has turned out to be predominantly women between the ages of 20 and 50 (the official limits are 17 to 50 years of age). Patients were placed at random on the amphetamine-combination drug or no drug. In accordance with our usual clinic routine, patients were weighed each week, given the same nutritional counseling, and allowed to participate in the same group discussions. Those patients given the medication were told that this was merely an aid to their reducing program, and no mention was made of the possible side effects. At the end of a 10-week test period the results were tabulated. As it turned out, through drop-out and medical screening, there were 25 patients in the drug group and 18 patients in the control group.

RESULTS

The drug group had a mean age of 37.4 years, with a range of 25 to 49 years (the mean age for the clinic population is 40.1 years). Patients were admitted to our clinic population only if there was no other medical problem. Thus we kept our study confined to patients whose only apparent problem was obesity.

Although the clinic was open to anyone in the Baltimore City and county area, we never were

able to attract more than one or two males (who dropped out, evidently due to the preponderance of females). No Negroes stayed in the study for longer than one session, for reasons which are speculative and may be discussed in future papers. All patients were American citizens. All but two patients were second to third generation housewives, and two women were married but working at outside employment.

Over the 10-week test period, the drug group (Group 1) lost an average of 20.2 pounds, or slightly over two pounds per week, with a range of 11 to 34 pounds. The control group (Group 2) had a mean age of 38.33 with a range of 27 to 49 years. The average 10-week weight loss was 9.61 pounds, or slightly less than the expected one pound per week. Those patients who did not attend the clinic sessions beyond their initial work-up (physical and blood work, as well as psychological testing) were counted as drop-outs and never actually entered into the study reported here. The range of weight loss for Group 2 was from one to 19 pounds over the 10 weeks. Thus, the group on the amphetamine preparation was able to lose twice as much, on the average, as the control group. Only two patients in Group 1 complained of amphetamine side effects, such as nervousness or mild insomnia, but these symptoms disappeared after two weeks of therapy.

The results of our various psychological and medical data are still to be summarized, and the final program of the clinic will be undecided until the clinic has been in existence for one year. Then we should be able to find out if the patients' weight loss has been maintained, and we will be able to correlate our psychometric data with the weight-reduction data. We will also attempt to delineate the personality profile of the obese individual who can lose weight and who will maintain this loss.

Since most of the obese patients in this country appear to be women,[19] our clinic population represents what most practitioners will face in their future attacks on obesity.

Anti-Calory Clinic
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REFERENCES

1. Adlersberg, D., and Mager, M.E.: Results of Prolonged Medical Treatment of Obesity with Diet Alone, Diet and Thyroid Preparations, and Diet and Amphetamines, *J Clin Endocrinol* 9:275, 1949.
2. Barnes, R.H.: Weight Control—A Practical Office Approach, *JAMA* 166:898-903, 1958.
3. Barnes, R. H.: Use of Anorexigenic Agents in a Weight Reduction Clinic, *Northwest Medicine,* 1958.
4. Clarke, H. J.: The Rosenzweig Picture-Frustration Study, in Anderson, H. H., and Anderson, G. L. (eds.): *An Introduction to Projective Techniques.* New York: Prentice-Hall, 1951.
5. Clarke, H. J., Roserzweig, S., and Fleming, E. E.: The Reliability of the Scoring of the Rosenzweig Picture-Frustration Study, *J Clin Psychol,* 3:364-370, 1947.
6. Duncan, G. G., Jenson, W. K., Cristofori, F. C., and Schless, G. L.: Control of Intractable Obesity, *Amer J Med Sci,* 245:515-520, 1963.
7. Fazekas, J. F., Ehrmantraut, W. R., and Kleh, J.: A Study of the Effectiveness of Certain Anorexigenic Agents, *Amer J Med Sci,* 236: 1958.
8. Gelvin, E. P., and McGavack, T. H.: Dexedrine and Weight Reduction, *New York State J Med* 49:279, 1949.
9. Gelvin, E. P., and McGavack, T. H.: *Obesity, Its Cause, Classification and Cure.* New York: Paul B. Hoeber, Inc., 1957.
10. Goodman, L. S., and Gilman, A.: *The Pharmacological Basis of Therapeutic.* New York: Macmillan Co., 1955.
11. Gryfe, A. M., Wardlaw, J. M., Grapko, M. F., Daley, D. E., and McLaren, B. A.: *J Canad Diet Ass,* 22: 122, 1960.
12. Hathaway, S. R., and McKinley, J.C.: *Minnesota Multiphasic Personality Inventory Manual.* New York: The Psychological Corporation, Rev., 1951.
13. Huntley, R. R.: The Cornell Medical Index Health Questionnaire as a Diagnostic Aid, *N Carolina Med J* 2:50-52, Feb., 1960.
14. Kroger, W. S., and Freed, S. C.: *Psychosomatic Gynecology.* Philadelphia: W. B. Saunders Co., 1951.
15. Ossermann, K. E., and Dolger, H.: Obesity in Diabetes: A Study of Therapy with Anorexogenic Drugs, *Ann Intern Med* 34:72-79, 1951.
16. Rosenzweig, S.: The Picture-Association Method and its Application in a Study of Reactions to Frustration, *J. Personal* 14:3-23, 1945.
17. Rosenzweig, S.: A Test for Types of Reaction to Frustration, *Amer J Orthopsychiat* 5:395-403, 1935.
18. Wardlaw, J. M., and McLaren, B. A.: Long Term Studies with Overweight Women, *Triangle,* V, 3: 145-151, Sept., 1961.
19. Warneche, G.: *Diethylpropion Therapy in Gynecologic Practice.* Medizenesche Welt No. 20, 1961, p. 1109.
20. Williams, R. H., Daughaday, W. H., Roger, W. F., Asper, S. P., Jr., and Marks, H. H.: Obesity and its Treatment with Particular Reference to the Use of Anorexogenic Compounds, *Ann Intern Med* 25: 510-532, 1948.



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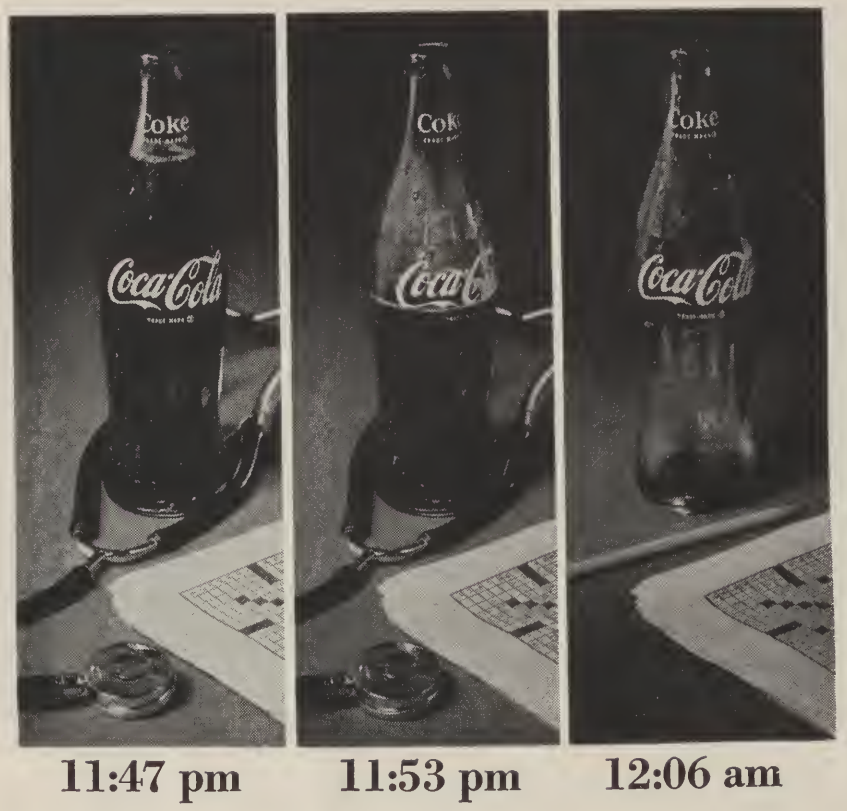
SEVERAL PHYSICIANS, WHO are members of Governor Tawes' Commission on Aging, visited nursing homes in and around Baltimore during recent years. It was the consensus that few, if any, facilities were available where patients might occupy their time. Similar observations have been made by other visitors at the various nursing homes.

The need for nursing home patient activity is readily apparent and urgent. Fortunately, a program designed to relieve or help alleviate this condition is now in progress with headquarters at Keswick. This organized effort, called the Maryland Program for Occupational Therapy Assistants, is being conducted by the State Department of Health as the result of a three-year training grant from the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare.

The first such training program, established under the standards of the American Occupational Therapy Association, was conducted from 1960 to 1963 in Montgomery County. The base of operations was transferred to Baltimore in 1963 so that it would be more readily available to the state as a whole.

The project includes 16 weeks of full time theory and practice for persons who would like to be employed part time or full time as occupational therapy assistants in nursing homes or similar institutions. In order to qualify for admission to the course, the applicant must have had a high school education. The first group in the Baltimore area, a class of nine students, graduated on March 15, 1964. The second group with 11 students finished on July 17, and the third group, also with 11, on December 23.

Graduates serve as sub-professional workers under the supervision of registered occupational therapists. Those persons who trained in the Montgomery County classes are, for the most part, working in proprietary nursing homes, and the quality of their work has been excellent. They



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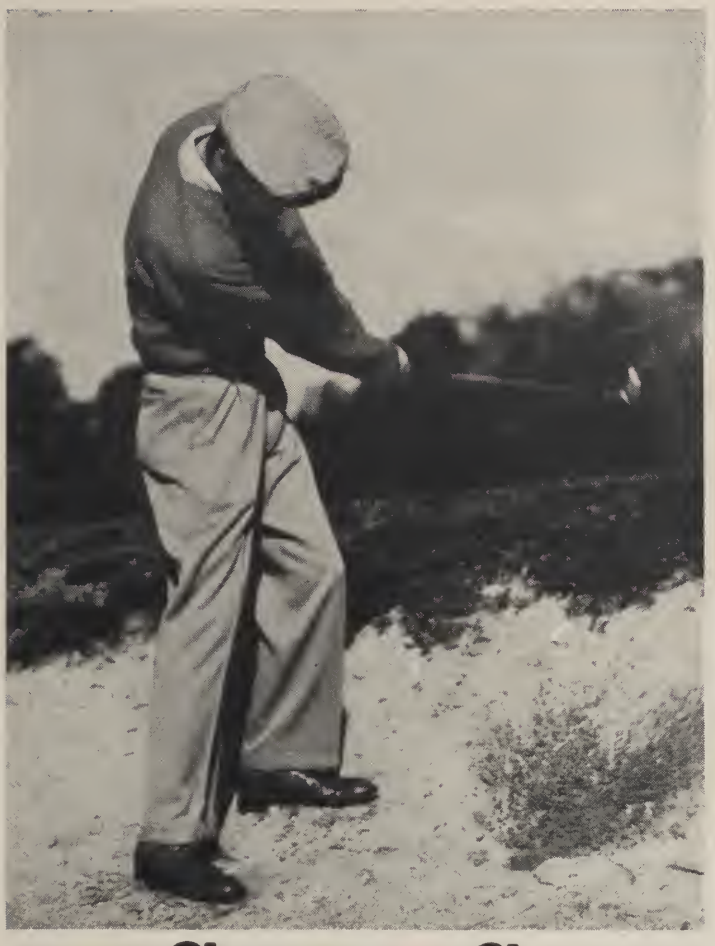
have aided immeasurably in improving the overall attitude of the patients as well as the atmosphere of the home where they are employed.

Many patients respond promptly to the efforts of the occupational therapy assistants. A good example of such a reaction is that of Mrs. R. T., a patient who is 78 years old and had become definitely withdrawn during the several years she had been at Keswick. Whereas Mrs. R. T. was capable of being ambulatory as well as caring for her personal needs, she would frequently remain in bed with her face turned to the wall, apparently withdrawn from the members of the Keswick staff and the other patients. Such behavior might be precipitated by losing or misplacing some personal article, or some imagined oversight or neglect on the part of the staff, or possibly some "snub" by one of her fellow patients. This patient's response to the attention of the occupational therapy assistants was revealing, as she quickly began to participate in the crafts offered her. This, along with the friendliness of the assistants and others, removed her from her shell of isolation.

A large number of aged, chronically ill patients spend many years in nursing homes and undergo a retrograde or steady downhill course unless some positive steps are taken to help them. It is well known that this gradual deterioration need not occur, and it can be temporarily reversed—or at least slowed—when the patients maintain the most active existence of which they are capable.

It is an established fact that the aged chronically ill patient will have fewer complaints and will improve rather than lose ground if he continues to lead an active life. Many such patients spend years of their lives in nursing homes, and they are better off with more things to do, especially craft work and social activities, to make life worth living.

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"UP AND AROUND" PUBLISHED

Up and Around, a 37-page extensively illustrated booklet to aid stroke patients in relearning to perform daily activities independently, has been published by the Heart Disease Control Program of the U. S. Public Health Service. Technical material for the publication was developed by Florence I. Mahoney, MD, director of physical medicine and rehabilitation, and Dorothea W. Barthel, PT, chief of physical therapy, Maryland State Chronic Disease Hospitals.

Prepared to help doctors, nurses, therapists, and families to teach stroke patients how to take care of their daily needs, the booklet contains more than 100 pictures and brief explanatory text. Instructions include step-by-step illustrations of such activities as sitting up in bed and moving from a bed to a wheelchair, with easy to follow directions for dressing, walking, climbing stairs, and entering and leaving an automobile.

The rehabilitation specialists advocate that the patient do as much as possible for himself as soon as feasible; however, the booklet emphasizes the fact that the doctor must decide when it is safe for patients to start relearning these activities, set any necessary individual limitations, and recommend any necessary precautions. No activities should be attempted before the doctor prescribes them, the authors point out.

Nurses will find the booklet especially useful in assisting family physicians to instruct and encourage families of stroke patients, and the patients themselves, in the continuation of restorative measures after discharge from the hospital. It is also excellent aid for persons who provide care for stroke patients in nursing homes.

Single copies of *Up and Around* are available without charge from the Public Inquiries Branch, Pub'ic Health Service, Washington, DC 20201. Additional copies may also be purchased from the Superintendent of Documents, Government Printing Office, Washington, DC 20402, at 50 cents each or $37.50 per hundred.

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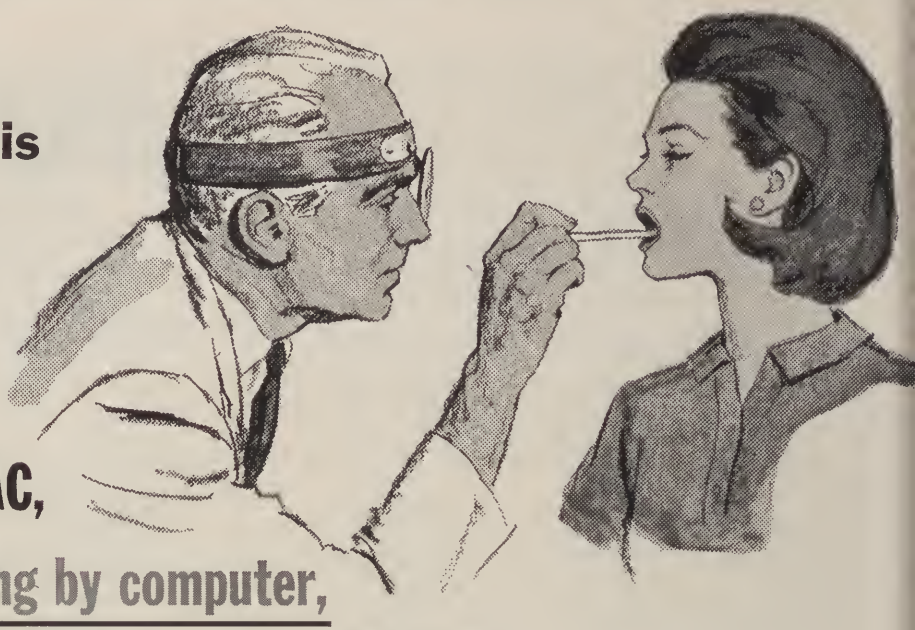
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ALLEGANY COUNTY

NEW STAFF OFFICERS OF SACRED HEART HOSPITAL

Calvin Y. Hadidian, MD, Cumberland chest surgeon, was elected president of the medical staff of Sacred Heart Hospital for 1965, succeeding **L. Michael Glick, MD.**

Elected vice-president is **Thomas F. Lusby, MD**; secretary, **Nicholas Giarrita, MD**; and treasurer, **Elizabeth G. Brings, MD.**



Left to right: Robert Feddis, MD, Secretary Allegany County Medical Society; Frank T. Cawley, MD, president, Allegany County Medical Society; Louis A. M. Krause, MD, guest speaker

At a recent meeting of the Allegany County Medical Society, **Louis A. M. Krause, MD,** clinical professor of medicine at the University of Maryland, spoke on early Egyptian medicine based on his research of mummies recovered along the Nile.

He noted that many of the diseases found today were present then and were easily recognized by present histological standards.

An interesting speaker and a most pleasing personality, Dr. Krause delighted an appreciative audience.

PATHOLOGIST SPEAKS AT CARDIAC SEMINAR

Nicholas Giarrita, MD, pathologist at Sacred Heart Hospital, spoke on "Anatomy and Pathogenesis of Cerebrovascular Accidents" at the morning session of the third annual cardiac seminar, held at the Memorial Hospital Nurses' Home, Cumberland.

Dr. Giarrita is a member of the American College of Pathologists, the American Medical Association, Maryland Society of Pathologists, and the Allegany County Medical Society and is a diplomate of the American Board of Pathologists. Now serving as pathologist and director of laboratories at Sacred Heart Hospital he is also assistant clinical professor of pathology at West Virginia University Medical School.

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⚙ *Leslie E. Daugherty, MD*

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At the business meeting which followed, the Nominating Committee made the following recommendations for vote at the annual business meeting on December 4:

President-elect, **Arthur G. Siwinski, MD.**
Vice-President, **Harry J. Connolly, MD.**
Secretary, **B. Martin Middleton, MD.**
Treasurer, **William F. Pearce, MD.**

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Directors to the Board of Directors for 1965 and 1966, George Govatos, MD, John F. Hogan, Jr., MD, and D. Frank Kaltreider, MD.

⚙ *Joseph D. B. King, MD*

MONTGOMERY COUNTY



John P. Haberlin, MD

John P. Haberlin, MD, Silver Spring, is the newly elected president of Montgomery County Medical Society.

Doctor Haberlin, is a native of Providence, RI, and a graduate of Yale University School of Medicine. He is a diplomate of the American College of Surgeons and has been chief of the Department of Surgery at Holy Cross, a 250-bed hospital, since its opening.

He served as treasurer of this society during 1961 and 1962, secretary in 1963, and vice president in 1964.

Other officers elected for 1965 are:

Vice president, **Seruch T. Kimble, MD,** Silver Spring, internist

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Secretary, **Carolyn S. Pincock, MD,** Silver Spring, pediatrician
Chairman, professional relations, **James A. Roberts, MD,** Silver Spring, internist

* * *

Stanley I. Wolf, MD, Silver Spring pediatrician, was presented the Doctor of the Year award by **John J. Curry, MD,** president of the Society, for "his excellent performance as chairman of the Stop Polio Campaign."

* * *

John J. Curry, MD, was cited by the Heart Association of Maryland at its annual meeting on October 1.

The citation stated, "In grateful recognition of dedicated service in advancing the fight against diseases of the heart and circulation." It was signed by **William R. Milnor, MD,** president, Heart Association of Maryland.

In addition to being chairman of the annual meeting program committee, Heart Association of Maryland, Dr. Curry is chairman of the Council on Professional Education, Heart Association of Maryland, and a member of the board of directors and medical advisory committee of Montgomery County Tuberculosis and Heart Association.

* * *

Ernest A. Bray, MD, a new member of Montgomery County Medical Society (U.S. Army MC, Retired) was recipient of the Sir Henry Wellcome Medal and Prize at the 71st annual meeting of the Association of Military Surgeons in Washington, DC. Doctor Bray's prize-winning article was an essay on "The End Results of Fractures of the Os Calcis."

* * *

The Montgomery County chapter of the American Cancer Society elected **Abraham W. Danish, MD,** president of the board, and **William Swatek, MD,** treasurer. **Mr. Harry R. Switzer** was presented with an engraved gavel for his service as president of the unit for the past four years.

* * *

Marvin I. Mones, MD, secretary of Montgomery County Medical Society, has been elected to the executive committee of the Maryland State chapter of the American Academy of Pediatrics.

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AUTOSOMAL CHROMOSOME DEFECTS IN HUMAN DISEASE

NORMAL HUMAN CELLS in mitosis possess 46 chromosomes. One pair, the sex chromosomes X and Y, are vastly different in size and shape. The other 44 chromosomes, the autosomes, are composed of homologous pairs, with the members of each pair alike in size and shape. The homologous pairs are separable into seven groups. Each group may be distinguished from members of other groups with relative ease, but the members within each group are so close in size and shape that normally they may not be distinguished from one another. Notable exceptions are chromosome pairs 1, 2, 3, and 18.

Assistance in further distinguishing certain of the autosomes with greater confidence may be found by two means. First is by means of identification of the patterns of DNA replication with respect to time by autoradiography. In a given cell, DNA replicates at different times, resulting in characteristic bands of radioactivity in certain areas of chromosomes. Second is the recognition of characteristic secondary constructions in the arms of the chromatids of certain chromosomes. Thus, the above, coupled with classical morphologic features, permits clearer identification of particular chromosomes associated with congenital malformation than was formerly possible.

While many abnormalities of autosomes have been reported in a wide variety of congenital malformations, there have been an insufficient number of examples of each to characterize more than three syndromes, each associated with an extra autosome (trisomy): Down's syndrome or mongolism (trisomy 21), trisomy of group E (13-15), and trisomy 18 syndromes. All autosomal abnormalities thus far described have represented an extra chromosome or a part of a chromosome. The deletion of an autosome has not yet been described, and the inference is that such deletion is lethal. Theoretically, there could be trisomy for each autosome, but only a few examples of trisomy of other chromosomes have been reported. Others will doubtless be observed, but most, evidently, are lethal early in gestation.

Most trisomies appear to be the result of meiotic non-disjunction of ova or sperm, in which the offending gamete received both members of a homologous pair of chromosomes. This produces the characteristic chromosome number of 47 in the fertilized zygote, which number can be found subsequently in all cells of the body. On the other hand, in certain individuals, cells from some tissues possess trisomic chromosomes, while cells from other tissues have a normal chromosome pattern. This is supposed to occur after fertilization by a process of mitotic non-disjunction, giving rise to two stem lines of cells, one with 46 chromosomes and one with 47 chromosomes. Evidence points to the fact that individuals with such mosaic chromosome patterns often display a less severe form of the particular trisomic syndrome concerned.

Interest has centered on unusual shapes of chromosomes, usually regarded as the result of translocation of part of a chromosome or an entire chromosome to another. Normal individuals may thereby possess an abnormal number of chromosomes, 45, but the karyogram reveals an abnormal chromosome made up of two translocated normal chromosomes. This occurs in some examples of "familial" mongolism, where a normal parent may have an abnormal number of chromosomes, 45, one of which is chromosome 21 translocated to another chromosome (22 or 15). Mongol offspring of such a parent may show a normal chromosome count of 46, but the abnormal chromosome, bearing the extra chromosome 21, will be present causing the trisomic state.

Finally, other types of abnormal shapes of chromosomes may result from fragments of

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chromosomes being added to or inserted into normal chromosomes. In this situation, a "partial trisomic" state may result, which is recognized clinically by some of the characteristic defects and cytogenetically by the presence of a chromosome of unusual shape. This has been most convincingly demonstrated in the trisomy 18 syndromes, but doubtless will ultimately be demonstrable in other trisomic states as well.

Considerable effort is being expended in the types of research outlined above with the ultimate hope of further characterizing autosomal abnormalities and attempting to understand their genesis. Much has been learned in the past several years which not only stimulates interest but also provides a firmer base for genetic counseling by the clinician.

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The Heart Page

George C. Roveti, MD—*Editor*

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THE CARDIAC PATIENT AS A SURGICAL RISK

CHRIS PAPADOPOULOS, MD

THE PHYSICIAN IS OFTEN CONFRONTED with the problem of the cardiac patient who has to have a surgical procedure. Many cardiac conditions formerly considered inoperable are now operable, and many cardiac patients with other conditions in which operations are indicated may now undergo surgery with proper cardiac and medical therapy. It has been pointed out that it may be less hazardous, on some occasions, to operate upon a well-compensated patient with coronary artery disease than to allow a secondary disease process, such as cholecystitis or prostatic disease, to persist with possible aggravation of the patient's condition or to progress to an acute situation which, in this setting, may be fatal.

Surgical risk is greater in patients with coronary disease than in other forms of heart disease, the mortality rate being about two to three times the overall surgical mortality rate. The average of several series collected by Nachlas et al[1] shows a mortality of 6.6%, with a 2.9% mortality in the controls. The actual risk in a given patient depends upon several factors which relate to the nature of the clinical manifestations and complications of the coronary disease.

Coronary insufficiency represents an unpredictable risk. Patients with this condition are susceptible to sudden, unexpected death with or without development of thrombotic occlusion. "Ischemic or arrhythmic" death may occur during surgery as it does under the usual stresses of daily living. The risk for a patient with angina pectoris and an abnormal EKG is higher than that for the patient with a normal EKG. The surgical risk becomes higher in the patient who has had a previous coronary occlusion, as evidenced by the following observation. Patients with pre-existing coronary occlusive disease had a postoperative incidence of additional coronary occlusion amounting to 6%. In contrast, patients with no history of prior coronary occlusion had a postoperative incidence of only 0.7%.[2]

The risk of a fatal or non-fatal complication in a patient who had preoperative myocardial infarction is related to the interval between preoperative infarction and the time of the operation. Emergency life-saving surgical procedures have to be done even in the face of an acute state of infarction. Elective surgery, however, should be deferred until six months after myocardial infarction. Important complications of coronary disease which have been considered as risk factors include arrhythmias, conduction disorders, cardiomegaly, and myocardial failure. If the risk is to be reduced, patients with these complications should have careful preoperative evaluation, and corrective measures should be taken to obtain maximal improvement prior to surgery.

Factors modifying the surgical risk are: 1) Presence of associated diseases, such as hypertension, valvular disease, anemia, diabetes mellitus, electrolyte disturbance. 2) The age of the patient. 3) The type and duration of surgery. Operative procedures on the intestinal and urinary tract, thoracic procedures, and major gynecologic and genito-urinary procedures tend to provide greater risk. 4) The anesthetic agent. The type of anesthetic agent used may modify, but not significantly, the risk factor. The competent anesthesiologist is capable of utilizing each agent, and the selection

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should be left to his evaluation of the problem. 5) Preoperative and postoperative management.

The medical evaluation of the patient who is to be operated upon should be concerned with providing advice for preparing the patient for surgical therapy. Every patient going to surgery has to be well compensated cardiac-wise. Evidence of heart failure should unquestionably be corrected with digitalis. Digitalization preoperatively is, however, advocated whenever there is a previous history of impaired cardiac reserve or definite congestive heart failure, even if the patient appears to be well compensated. This is particularly true of patients over the age of 50 who have definite evidence of coronary artery disease. Patients with cardiac enlargement should also be digitalized prophylactically. The digitalized patient is better prepared to withstand the acute stress of anesthesia and surgery and is less likely to have heart failure during or after surgery.

Though the problem of routine preoperative digitalization is controversial, we agree with other internists and cardiologists that patients in the older age group who are to undergo major surgery and who have electrocardiographic changes or other evidence of coronary disease should be digitalized. The general impression is that the incidence of congestive failure and the incidence of postoperative arrhythmias are less in these patients.

Digitalization performed hastily and improperly may have adverse effects. Serious postoperative arrhythmias are most prevalent in patients who are either inadequately digitalized or overdigitalized before surgery.[3] The following should be considered in the preoperative management: 1) Digitalization of patients with frequent atrial premature beats. 2) Aggressive preoperative treatment of patients exhibiting cardiac arrhythmias produced by excessive digitalis therapy. 3) Discontinuation of myocardial depressant agents, such as quinidine and procainamide (Pronestyl) preoperatively. 4) Preoperative insertion of a bipolar electrode catheter into the right ventricle for emergency electronic pacing in patients with advanced second degree and third degree A-V heart block. 5) Withholding of all cardiac drugs in the operating room unless the arrhythmia compromises the cardiac output.

Rheumatic heart disease is associated with a lower surgical mortality rate than is coronary heart disease. The risk of surgical procedure is correlated to the functional state of the heart. The compensated rheumatic cardiac patient tolerates surgery well. Patients, however, with aortic stenosis, being usually susceptible to sudden death, present an increased risk.

Bacterial endocarditis usually is a complication of rheumatic, valvular, or congenital heart disease. For patients who have cardiac problems of this type, penicillin is an effective prophylactic agent before dental extractions, removal of tonsils and adenoids, and obstetrical delivery. Aqueous penicillin may be given immediately before and continued in conjunction with a longer acting preparation for one or two days afterward. If a contemplated operation in a patient with cardiovascular disease is one in which possible enterococcal invasion might be anticipated, streptomycin should also be administered.

When considering the patient who is on anticoagulant therapy, it is not necessary to stop medication if the surgical procedure is a simple one like a dental extraction. Teeth can be safely extracted when the prothrombin time is in the levels of the so-called "therapeutic range." If an emergency major surgical procedure is contemplated, many people advocate giving Vitamin K_1 intravenously as necessary. The prothrombin time must be near normal; otherwise, hemorrhage may be as serious as thrombosis. If surgery is elective, anticoagulants can be withdrawn slowly. It is not absolutely necessary to raise the prothrombin time to 100% in view of the fact that often the surgeon operates upon patients with liver disease without any untoward effects even when the prothrombin time is far below normal.

In conclusion, a cardiac patient, well prepared medically before operation and undergoing operation under competent anesthesia, should not be a real surgical risk.

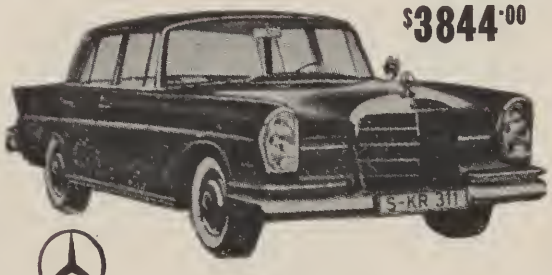
REFERENCES

1. Nachlas, M. M., Abrams, S. J. and Goldberg, M. M.: The influence of arteriosclerotic heart disease on surgical risk. Am. J. Surg., 101:447, 1961.
2. Knapp, R. B., Topkins, M. J. and Artusio, J. T.: The cerebral accident and coronary occlusion in anesthesia. J. A. M. A., 182:332, 1962.
3. Dreifus, L. S., Rabbino, M.D., Watanabe, Y. and Tabesh, E.: Arrhythmias in the postoperative period. Am. J. Cardiol., 12:431, 1963.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

MONTGOMERY COUNTY PROGRAM FOR ALCOHOLICS

FRANCIS J. RYAN, DSW
Executive Director
Family Service of Montgomery County, Inc.
and
JANE F. CARRIGAN, MA
Alcoholic Program Co-Director
Family Service of Montgomery County, Inc.

WHAT IS MONTGOMERY COUNTY doing for its estimated 10,000 alcoholics? This question interested the board of directors of Family Service of Montgomery County, and the answer—very limited service—led to the development within the agency of a counseling program for the alcoholic and his family.

Doors opened in September for this project, which is still in the formative stage. It represents a departure from tradition, as customarily a family service agency does not develop a counseling program around a specific problem. But such an approach is particularly useful to the alcoholic and his family, according to Anthony Zappala, MD, former director of the Washington, DC, Alcoholic Rehabilitation Clinic and presently psychiatric consultant to Family Service of Montgomery County. Dr. Zappala contends that the alcoholic, misunderstood and rejected if his drinking problem is ignored, may best be helped in a group with similar problems, where he can establish a helpful relationship with personnel having particular interest and skill in dealing with them.

Tackling the problem that alcoholism represents for a family seems to fit the concept of a family agency. Mrs. Gertrude L. Nilsson, coordinator, Services to Alcoholics, Maryland State Department of Mental Hygiene, recognized this when she arranged for the Department to fund the project. Further, she believes that an effective demonstration pointing out that a non-medical agency can be useful to the alcoholic and his family might mean that many other non-medical organizations, such as welfare departments, could develop similar plans.

While the program raises the issue of the illness concept in relation to alcoholism, it is thought that the social aspects as well as the medical should be viewed. This program concerns itself with the interpersonal relationships of the alcoholic and his family, both within and outside the home. When medical care is indicated, the alcoholic is referred to a medical doctor, preferably his family physician.

The Montgomery County project focuses on group counseling of the alcoholic and his family. Plans call for the formation of a group of married couples as well as a group of non-alcoholic spouses. Analyses of caseloads of family service agencies suggest that a non-alcoholic member of a family is often the first to come for help around an alcoholic problem. It is frequently the case with these families that the alcoholic is in the earlier phases of alcoholism, has not recognized his problem, and is still able to function more or less

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effectively. It is hoped that, as research within the program develops, new methods for reaching the early-phase alcoholic will emerge.

The program, limited in scope today, has an active and enthusiastic advisory committee, on which the medical profession is well represented, which recognizes the need to educate the community by developing the program further and interpreting it to the people of Montgomery County. It is hoped that this committee will form, in time, the nucleus of a Montgomery County Council on Alcoholism.

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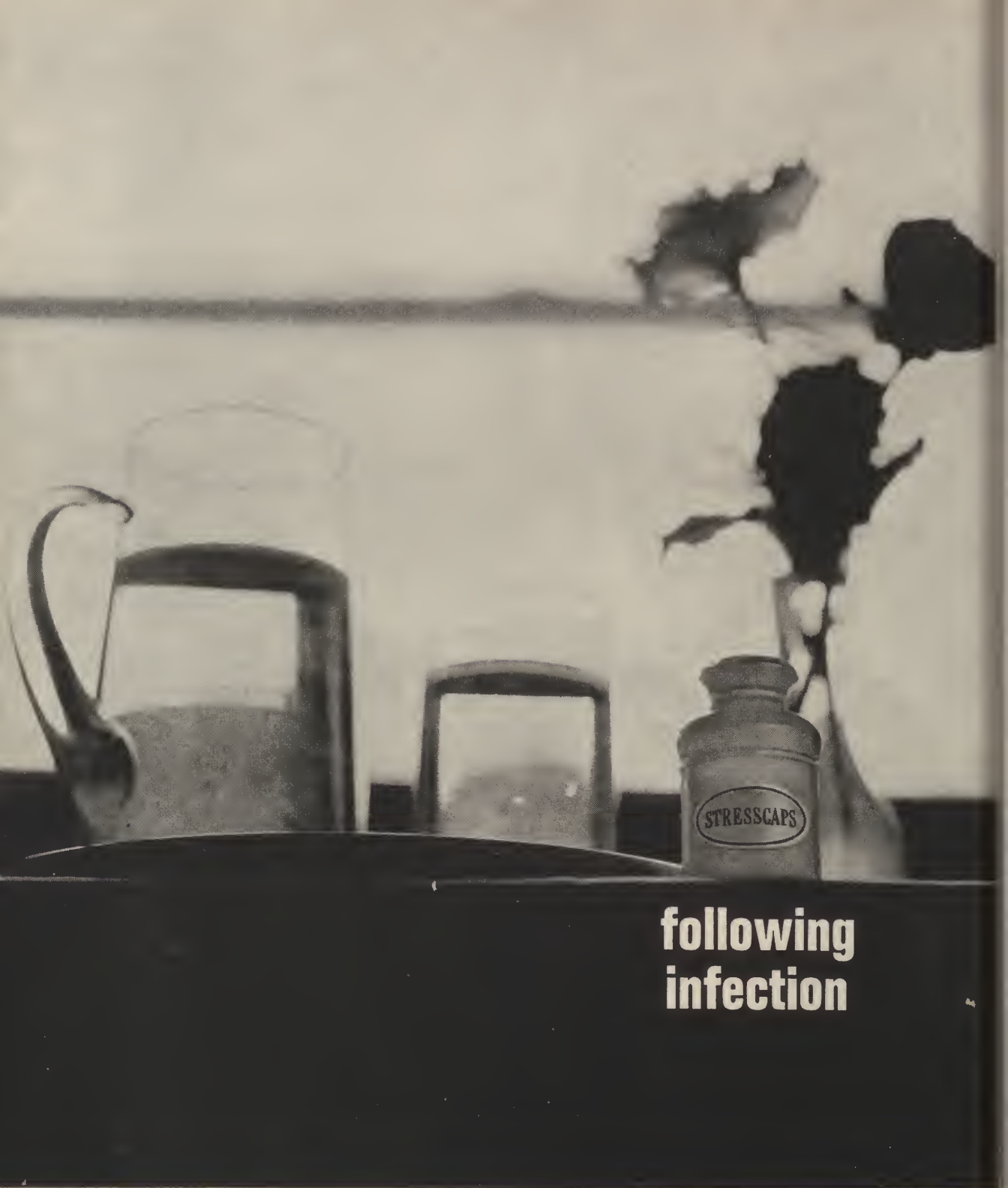
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REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

EVALUATION
The First Step in Rehabilitation

THE PURPOSE OF REHABILITATION is to help the patient reach maximal independence. Because patients needing rehabilitation generally have a chronic impairment, rearrangement of social factors and readjustment of the patient himself may be factors of major importance in attaining maximal independence. Just as effective medical treatment depends on accurate medical diagnosis, so effective rehabilitation must be based on an adequate evaluation of the patient's physical, mental, and social performance. Only when impairments and resources are identified accurately can steps be taken to formulate a plan for rehabilitation.

INVENTORY OF IMPAIRMENTS AND RESOURCES

Medical evaluation: An evaluation of the patient's rehabilitation potential must start with an accurate medical diagnosis. This is fundamental and by far the most important information in planning rehabilitation, but it does not tell us what the patient is able to do for himself and what he lacks to regain independence.

Functional evaluation: To estimate what the patient is actually able to do to help himself in the performance of every day tasks of living, we must see him in action. The state of bowel and bladder control, the presence of decubitus ulcers and contractures, the state of communication (speaking, hearing), the ability to feed, wash, dress, wheel a chair, move from bed to wheel chair and back, and get on and off a toilet from a wheel chair are activities essential for minimal independence. Finally, the ability to ambulate and ascend and descend stairs completes the inventory of the activities necessary for self-care.

A number of systems evaluating activities of daily living have been developed. Some of these may be scored to give a rough indication of the degree of impairment present.

The listing of these functions are as essential to the planning of rehabilitation as a physical examination is to the diagnosis. For example, if the patient is able to do all activities except stair climbing, it will be the purpose of treatment to teach the patient to go up and down the stairs. Thus, the inventory of daily activities directs attention to which functions are lacking and serves as an indication of how the patient is progressing.

Mental evaluation: Since a great many patients needing rehabilitation are elderly, some estimation of their orientation in time and place, their familiarity with everyday news of importance, and particularly their ability to follow directions may be of great importance in predicting whether they have the necessary intellectual ability to learn what is being taught them to increase their physical independence. Generally, an estimation of this parameter can be gotten by merely asking them to tell the date and place and to perform a simple subtraction test. A number of more elaborate

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tests are available but require time and grading.

Of equal importance with orientation is the patient's motivation. This parameter has been impossible to measure. In general, however, the physician who has taken the history and done a physical examination and talked with a patient will obtain a valid estimation of the patient's motivation to improve his independence. Alertness, energy, degree of cooperation, and realism of the goal are generally indicative of good motivation. Confusion, depression, poor cooperation, and inability to accept disability are poor prognostic signs in motivation.

Social evaluation: The make-up of a patient's social environment can generally be included under his family, his home, his finance, and his vocational background. These areas may be graded into four decreasing grades. Grade one is a good situation, grade two is fair, grade three is used when the situation is uncertain, grade four is when there are no resources in the category named.

Social evaluation is particularly important for elderly patients with multiple disease, mental impairment as well as social problems. In each of these social categories, there may be private or public organizations which may be of help in getting information or in ameliorating the situation.

Follow-up: A number of surveys have shown that a large number of patients do not comply with physician recommendations. From 30 to 50 per cent of patients do not follow prescribed drug requirements. An even higher percentage fail to receive recommended rehabilitation services such as physical therapy, home nursing care, social service referrals, vocational evaluation and training, and household help. In chronic diseases a major effort must be made on the part of the physician, the patient, and the family to sustain what may be a new way of life for the patient. It is essential, therefore, for the personal physician to evaluate not only the patient's potential but also the resources of the family.

An organized comprehensive evaluation of all patients with chronic disease when they are seen by their personal physician is the foundation of good medical care. The evaluation should take into account the patient's diagnosis, medical treatment, physical impairments, mental and emotional resources, and social considerations (family, housing, finance, and vocation). Identification of the factors which prevent full development of a patient's independence should motivate the personal physician to mobilize the community resources to help the patient become more independent. Resources include hospitals, rehabilitation centers, physical therapy departments, Instructive Visiting Nurses, Social Welfare Board, Welfare Department, State Office of Vocational Rehabilitation, and many other agencies which should be used to insure maximal medical care for each patient. Although some needed resources are lacking, the full use of what is available would prevent the tragedy of patients living below their full potential.



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BRIGHTER VISTA FOR THE RETARDED

Until fairly recently, patients whose mental retardation was caused by inherited metabolic defects were written off as untreatable. But a number of these conditions, in addition to phenylketonuria, now "can be rationally treated with expectation of amelioration if not of cure."

This opinion, shared by many of the experts attending the International Copenhagen Congress on the Scientific Study of Mental Retardation, was advanced by Britain's Prof. Lionel S. Penrose, the first researcher to suggest the correction of phenylketonuria through a low-phenylalanine diet. Professor Penrose now groups together all retardation conditions caused by direct gene interference with cerebral function. If this classific action is accurate, he says, "there is a good prospect of successful treatment."

Although cystathioninuria and citrullinuria are "imponderables," the autosomal recessive aminoacidurias eventually may yield to therapy, according to Professor Penrose, a researcher at London's University College. Suggested therapy would minimize the dietary intake of imperfectly metabolized amino acids. One of the main roadblocks to this approach, the British researcher notes, is that standards of dietary prophylaxis have yet to be established.

Patients Respond to Diet

At the Copenhagen meeting, three University of Wisconsin researchers described a study of biochemical control in the dietary treatment of phenylketonuria. Drs. Harry A. Waisman, Phyllis W. Bergman and Frances K. Graham report that such control "allows for development of intellectual ability far above that of the untreated child but not quite up to the attainment of normal siblings."

Dr. Waisman and his colleagues put 25 mentally retarded PKU patients on a restricted phenylalanine diet for periods of six months to eight years. A control group included 76 retarded PKU patients and the normal siblings of the 25 patients chosen for the study. All the children were examined once a month and given intelligence tests every six months. One of the treated patients, who had been on the special diet since the age of ten weeks, scored 117 on his most recent IQ test.

The Wisconsin researcher also presented a report on homocystinuria, a condition caused by an inborn error of sulfur amino acid metabolism. About 30 cases of the disease have been detected,

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said Dr. Waisman, "and they all appear to have similar clinical findings."

Symptoms include dislocated lenses, convulsions, malar flush, prominent joints, and the excretion of homocystine. In certain cases, these symptoms are accompanied by mildly abnormal neurological reflexes, or by genu valgum, pes cavus, and seizures.

A negative urinary nitroprusside test excludes the diagnosis of homocystinuria, notes Dr. Waisman. "It is hoped that newly identified cases will be found, to obtain additional metabolic information. Also, diagnosis at an early age will allow treatment with cystathionine feedings in the hope that all signs of the disease can be prevented."

A number of other studies dealing with inborn metabolic errors were described at the Congress. Among the significant findings:

Prof. W. C. McMurray and a University of Western Ontario team suggested that citrullinuria may be triggered by a block in citrulline utilization, possibly caused by an inborn error of ornithine metabolism in the urea cycle. A study of the disease in a mentally retarded boy showed that citrulline levels in the blood and cerebrospinal fluid were 50 to 100 times above normal.

Professor McMurray observed that blood ammonia was moderately elevated in fasting states. After a protein meal, he reported, the hyperammoniemia was greater than that associated with hepatic coma.

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New Venereal Disease Clinic Opened In Western Health District Building

A NEW VENEREAL DISEASE clinic has been opened in the Western Health District Building, 700 West Lombard Street. This new clinic takes the place of the venereal disease clinic located at 414 North Calvert Street, which closed December 9 after 17 years of operation. The telephone number of the new clinic is VErnon 7-2710.

The City Health Department's venereal disease clinics are now held at three locations:

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Telephone: VErnon 7-2710

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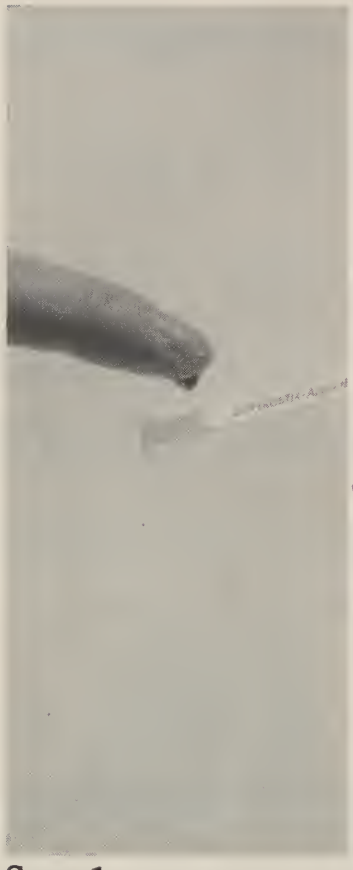
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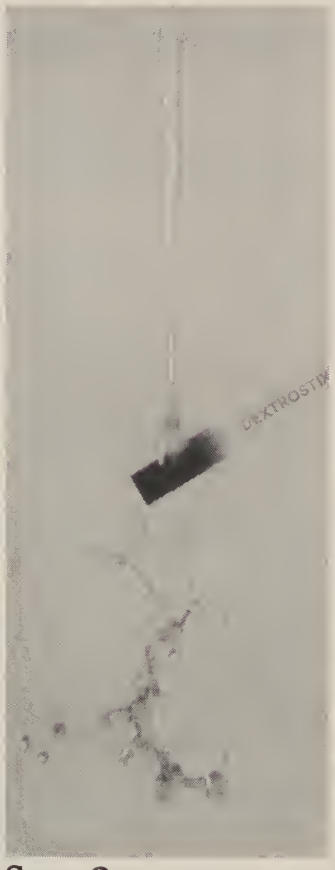
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*Spaulding, W. B.; Spitzer, W. O., and Truscott, P. W.: Canad. M. A. J. *89*:329, 1963.

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Civil Defense Emergency Hospital Training Program

HERBERT M. BATEMAN
Chief, Office of Health Mobilization

DURING THE PAST SEVERAL YEARS a sustained effort has been undertaken by the State Health Department and the State Civil Defense Agency to provide communities in Maryland with packaged emergency hospitals. Working jointly with the Division of Health Mobilization, Public Health Service, 32 of these packaged hospitals have been strategically placed to provide a community service in the event of a major disaster.

Packaged for long-term storage, these emergency hospitals contain sufficient medical and surgical supplies and equipment to afford the same service as a 200-bed general hospital. Each hospital is furnished with 200 cot beds, complete with blankets, pillows, and sheets. It also includes basic equipment to operate a hospital facility, a 15-kilowatt electric generator, a quick reading x-ray unit, bedpans, pitchers, towels, infusion stands, and other necessary supplies. There is also a laboratory, a pharmacy, and a well-equipped central supply section. Five operating tables are provided, along with operating lamps, sterilizers, and anesthesia equipment.

Although these packaged hospitals containing the essential medical supplies and equipment to function as a general hospital are provided at no cost to the community in which they are located, each community is responsible for designating a school, church, or similar type building in which the hospital can operate and for providing supporting services such as water, feeding facilities, laundry, mortuary, and communications. The prepositioned Civil Defense Emergency Hospital constitutes a community resource to be used to cope with the exigencies of a major disaster, and it is



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the community's responsibility to develop a program for the effective utilization of each of these units located within that community. Such a program should include a state-approved plan for establishing the hospital and should provide for ancillary and other supportive personnel necessary for the hospital to function and for proper training in uncrating, setting-up, and operating procedures.

The Stockpile Management Branch of the Public Health Service's Division of Health Mobilization currently is engaged in a program to supply each of the 32 pre-positioned Civil Defense Emergency Hospitals with additional medical and surgical supplies which will extend the operational capability from three to 30 days. In addition, to assure that each unit is kept completely operational at all times, the Stockpile Management Branch is maintaining a quality control program comprising an annual inventory and inspection of all items contained in each unit and servicing, repackaging when necessary, and replacing of all outdated "shelf-life" items.

In addition, it is expected that 18 of the new 1962 models, now being assembled with a 30-day operational capability, will be pre-positioned in the near future.

To assist the communities in training personnel to uncrate and set up the emergency hospital to care for casualties within a few hours or several days, the Maryland State Health Department, in conjunction with the State Civil Defense Agency, has developed a Civil Defense Emergency Hospital Training Program, which contains approximately one-quarter of a 1953 model Civil Defense Emergency Hospital, repacked in 77 multi-use containers, plus 30 cots to be used in shock and treatment wards.

Embodied in the training program is a training exercise plan for erection of a Civil Defense Emergency Hospital in a school, church, or similar building, which gives step-by-step do-it-yourself instructions that can be understood easily and used by supervised laymen working under simulated emergency pressure. A staff is available to assist in planning and executing a training demonstration.

A successful exercise requires the organized participation of local civil defense and health officials, hospitals, medical, and other related groups. From these groups, physicians, nurses, technicians,

aides, and other supportive personnel should be recruited and trained to function in an emergency.

Community civil defense directors and health officers need the cooperation of various professional and supportive groups to organize and conduct at least one training exercise yearly. Every completed exercise involving new personnel increases the reservoir of individuals oriented in the technicalities of setting up and operating an emergency hospital.

Every community in which a Civil Defense Emergency Hospital is stored is responsible for training key people to effect a rapid and orderly transition from packaged supplies and equipment to a functioning hospital. Without adequate planning, staffing, and training coordination, an emergency hospital in storage has no meaning.

To date, training exercises have been conducted in 12 communities, training a total of 148 physicians and 1,832 ancillary and supportive personnel in the procedures of uncrating, setting up and organizing an emergency hospital.

The success of the exercises conducted is due mainly to the support and cooperation of those physicians participating. Future training demonstrations will be held in communities which have not yet had this type of training. Physicians are urged to assist when called upon by county officials and to provide the professional leadership necessary for a successful exercise.



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Guest speaker for the luncheon on March 4 will be George Burch, M.D., Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cast of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-haur cocktail party with George Lewis and his band from Preservation Hall entertaining.

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PROBLEMS OF THE INNER CITY

ADMISSION RATES TO MARYLAND'S mental hospitals and to all psychiatric facilities are substantially higher in the central, inner core of Baltimore than in the city's outlying areas. As indicated in Table 1, these areas differ also in such socio-economic variables as the educational and income levels of their populations.

Table 1

	Inner City	Outside Inner City
Admission rates to state hospitals*	533.1	163.1
Admission rates to all psychiatric facilities*	1,095.9	632.2
Per cent of adults who are high school graduates**	28.2	40.7
Per cent of families with income under $3,000**	18.6	9.7

*Estimated rates per 100,000 population during 1963 fiscal year

**1960 census data

The relatively greater occurrence of public health problems, such as infant mortality and tuberculosis, among the economically and culturally deprived residents of the overcrowded slums has been noted in all cities. Hollingshead and Redlich, in a study in New Haven, and Srole and his associates, in a more recent study in midtown Manhattan, have reported a similar relationship between rates of known mental illness and socio-economic status.

In recent years, all cities have experienced a large scale, continuing out-migration from their central areas to the suburbs of middle class residents and their replacement by residents of a different and often lower cultural and economic level. Those who do not migrate are usually the old and the less mobile. This population movement has produced interrelated economic, educational, and public health problems in Baltimore, as in other cities. At the same time, this growing geographic dispersion has reduced social contact, and this in turn has reduced the public's awareness and understanding of the extent and implication of the problem.

In order to obtain information not now available, a series of detailed studies analyzing the effect of poverty and overcrowding on rates of treated mental illness in Baltimore are planned, using data from the Maryland Psychiatric Case Register. These data will be related to available statistics on the characteristics of the area and its population and on the incidence of other public health problems.

A national concerted anti-poverty program is being developed. The success or failure of this endeavor will have important bearings on future mental health needs. Active participation of all psychiatric agencies in close coordination with other services is therefore essential.

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WITH THE BEGINNING OF THE NEW YEAR, the Med-Chi library hopes to see more and more members using the resources available to them from its shelves and staff. In addition to the fact that every membership automatically includes library service, the library wishes members would suggest titles relating to their particular interests. This would be a tremendous aid to the librarian in selecting appropriate and vital books needed to keep the book collection growing and alive.

Following are some recent additions to our current listings:

American Association of Dental Schools: *Admission requirements of American dental schools.* 1964/65.

Atamer, M. A.: *Blood diseases.* Grune & Stratton, 1963.

Avery, Mary Ellen: *The lung and its disorders in the newborn infant.* Saunders, 1964.

Ayer (N. W.) & Son's: *Directory, newspapers and periodicals.* 1964.

Bauer, Donald de Forest: *Lumbar discography and low back pain.* Thomas, 1960.

Bio-medical purview: *Birth of a drug; research and development in the pharmaceutical industry.* Pharmaceutical Manufacturers Association, 1963.

Carter, Richard: *Your food and your health.* Harper & Row, 1964.

Color atlas of pathology. Lippincott, 1963.

Cooley, Donald Gray: *The science book of modern medicines.* Watts, 1963.

Fitzpatrick, William H.: *Soviet research in nutrition.* Institute of Contemporary Russian Studies, Fordham Univ. 1963.

Francis, Carl C.: *Introduction to human anatomy.* 4th ed. Mosby, 1964.

Glasscheib, Hermann Samuel: *The march of medicine.* (trans. from the German) Putnam, 1964.

Granit, Ragnar: *Sensory mechanisms of the retina.* Hafner, 1963.

Great Britain: *United Kingdom mission on the fluoridation of domestic water supplies in North America as a means of controlling dental caries.* H. M. Stationary Office, 1953.

Greenwood, Richard J.: *Sinoatrial heart block.* Thomas, 1964.

Handbook of chemistry. Handbook Publishers, 1961.

Israels, M. C. G.: *Diagnosis and treatment of blood diseases.* Thomas, 1963.

Jacobi, Charles A.: *X-ray technology.* Mosby, 1964.

Keown, Kenneth K.: *Anesthesia for surgery of the heart.* 2nd ed. Thomas, 1963.

Kraus, Hans: *Therapeutic exercise.* 2nd ed. Thomas, 1963.

Lerner, Monroe: *Health progress in the United States, 1900-1960.* Univ. of Chicago Press, 1963.

McCarthy, Philip L.: *Diseases of the oral nucosa.* Blakiston-McGraw Hill, 1964.

Moore, Francis D.: *Give and take, the development of tissue transplantation.* Saunders, 1964.

Peiper, Albrecht: *Cerebral function in infancy and childhood.* (trans. from the German) Consultants Bureau, 1963.

Progress in cardiovascular diseases. Edited by Charles K. Friedberg, Grune & Stratton, 1963.

Rodale, Jerome Irving: *Our poisoned earth and sky.* Rodale Books, 1964.

School Health Education Study, 1961-63. Washington, D. C., 1964.

Starobinski, Jean: *A history of medicine.* (trans. from the French) 1st ed. Hawthorn Books, 1964.

Stephenson, Hugh E.: *Cardiac arrest and resuscitation.* 2nd ed. Mosby, 1964.

Stewart, James Richard: *An atlas of vascular rings and related malformations of the aortic arch system.* Thomas, 1964.

Symposium on Metabolic Control Mechanisms in Animal Cells, Boston, 1963. Edited by William J. Rutter, National Cancer Institute, 1964.

U. S. National Institutes of Health: *Medical and health related science thesaurus.* U. S. Govt. Printing Office, 1963.

U. S. Public Health Service: *Medical school facilities planning considerations.* Washington, D. C. 1961.

Workshop on the Biology of the Prostate and Related Tissues, Warrenton, Va., 1962. Edited by Erwin P. Vollmer, U. S. Govt. Printing Office, 1963.

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Book Reviews

POLYPOID LESIONS OF THE GASTROINTESTINAL TRACT. Claude E. Welch, MD. Vol II in the series "Major Problems in Clinical Surgery." Saunders, 1964. $7.50

The author presents a modern point of view on the controversial question of appropriate management of polyps of the colon. He analyzes the nature of polyps and offers a program for management. His opinions are supported by his extensive personal experience in the past 10 years at Massachusetts General Hospital. Short case reports illustrate difficult decisions.

THE RETINAL VESSELS. COMPARATIVE OPHTHALMOSCOPIC AND HISTOLOGIC STUDIES ON HEALTH AND DISEASED EYES. R. Seitz, MD, translated by Frederick C. Blodi, MD. Mosby, 1964. $14.50

A number of advances in pathologic anatomy have contributed to better understanding of eye diseases, particularly degenerative diseases of the retina, retinal detachment, and pathologic alterations of the vitreous. This profusely illustrated monograph clarifies many misconceptions about pathologic processes of the retinal vessels.

MILESTONES IN NUTRITION, vol. 2. Samuel A. Goldblith, SM, PhD, and Maynard A. Joslyn, MS, PhD. AVI Publishing Co., 1964. $14.25

This is a compilation of papers pertaining to the discovery of the vitamins. Reproduced here are papers from the scientific publications of the past 150 years which highlight significant events in nutritional science.

REHABILITATION MEDICINE. A TEXTBOOK ON PHYSICAL MEDICINE AND REHABILITATION, ed 2. Howard A. Rusk, MD. Mosby, 1964. $15.50

This edition reflects many advances in this field during the past seven years, since publication of the first edition. A number of chapters have had to be extensively revised. Like the edition which preceded it, this is intended as an elementary textbook in what has been termed the "third phase of medicine."

THE MASK OF SANITY, ed 4. Hervey Cleckley, MD. Mosby, 1964. $9.75

This book attempts to clarify some issues about the so-called psychopathic personality. The author stresses the fact that he has no cure to offer, but he believes that previous editions have enabled the families and physicians of psychopathic patients to better understand the problems they have to face.

FUNDAMENTALS OF OTOLARYNGOLOGY, A TEXTBOOK OF EAR, NOSE AND THROAT DISEASES, ed. 4. Lawrence R. Boies, MD; Jerome A. Hilger, MD; Robert E. Priest, MD. Philadelphia: W. B. Saunders Company, 1964. $8.50.

This compact volume presents fundamental information for the undergraduate medical student and the physician who is not a specialist in otolarynogology. This edition is a departure from the previous editions in that it represents a team effort by outstanding members of the Department of Otolaryngology at the University of Minnesota Medical School. Previous editions had each chapter written by an individual contributor.

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Washington County Woman's Auxiliary began the year with an unusual project to raise money for nursing scholarships—a fur fashion show. A photographer's studio framed the setting of the show, entitled "Picture Yourself in Furs." Our models were Auxiliary members, and our coordinator, Marge Hoachlander, set the tone of the evening by her charm and fashionwise poise. Door prizes in fur were awarded, enabling many a lady to leave the show a bit richer than when she came. Our net profits were almost enough to send two girls through nursing school.

Allied to nursing, our Health Careers Committee is visiting every Future Nurses' Club in the county. This month we hope to entertain their officers at a tea.

We have helped the Washington County Medical Society in its Tetanus Campaign Week. In November we assisted in activating Diabetes Detection Week by placing posters and kits in stores.

A date in June has been selected to attend a play at the Totem Pole Playhouse, from which we can also share in the profits of the evening's performance.

Doctor's Day plans are quiet because our chairman just had a new baby and is attending to first things first. Quite a few new babies up here, which just goes to prove we're all young in Washington County!

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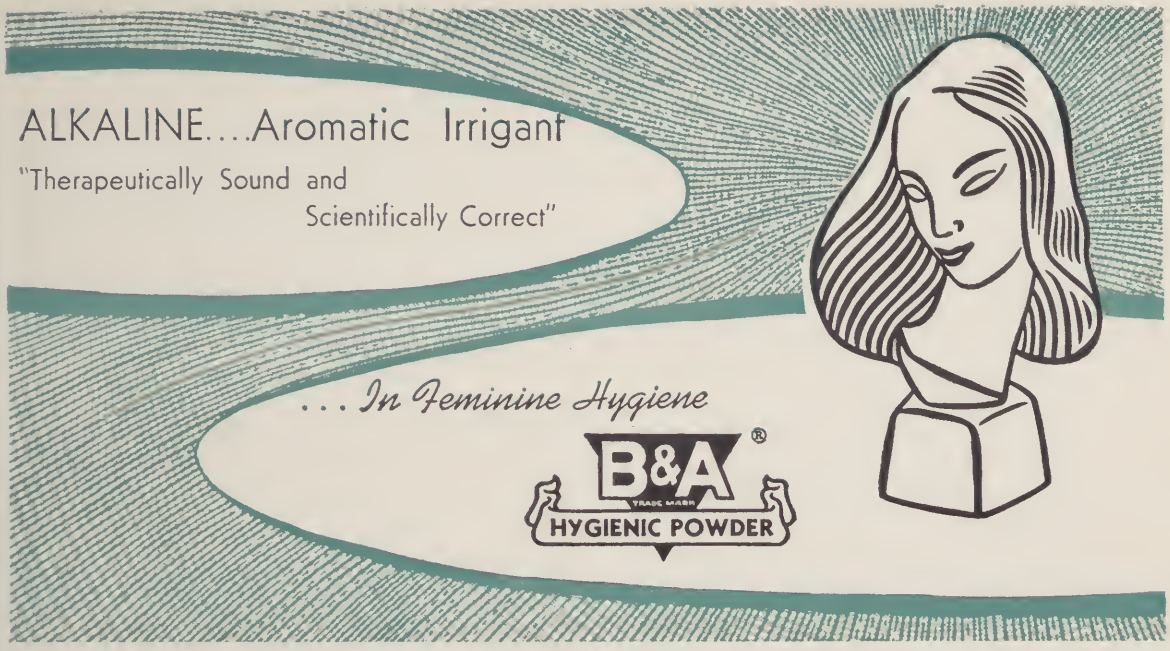
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(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

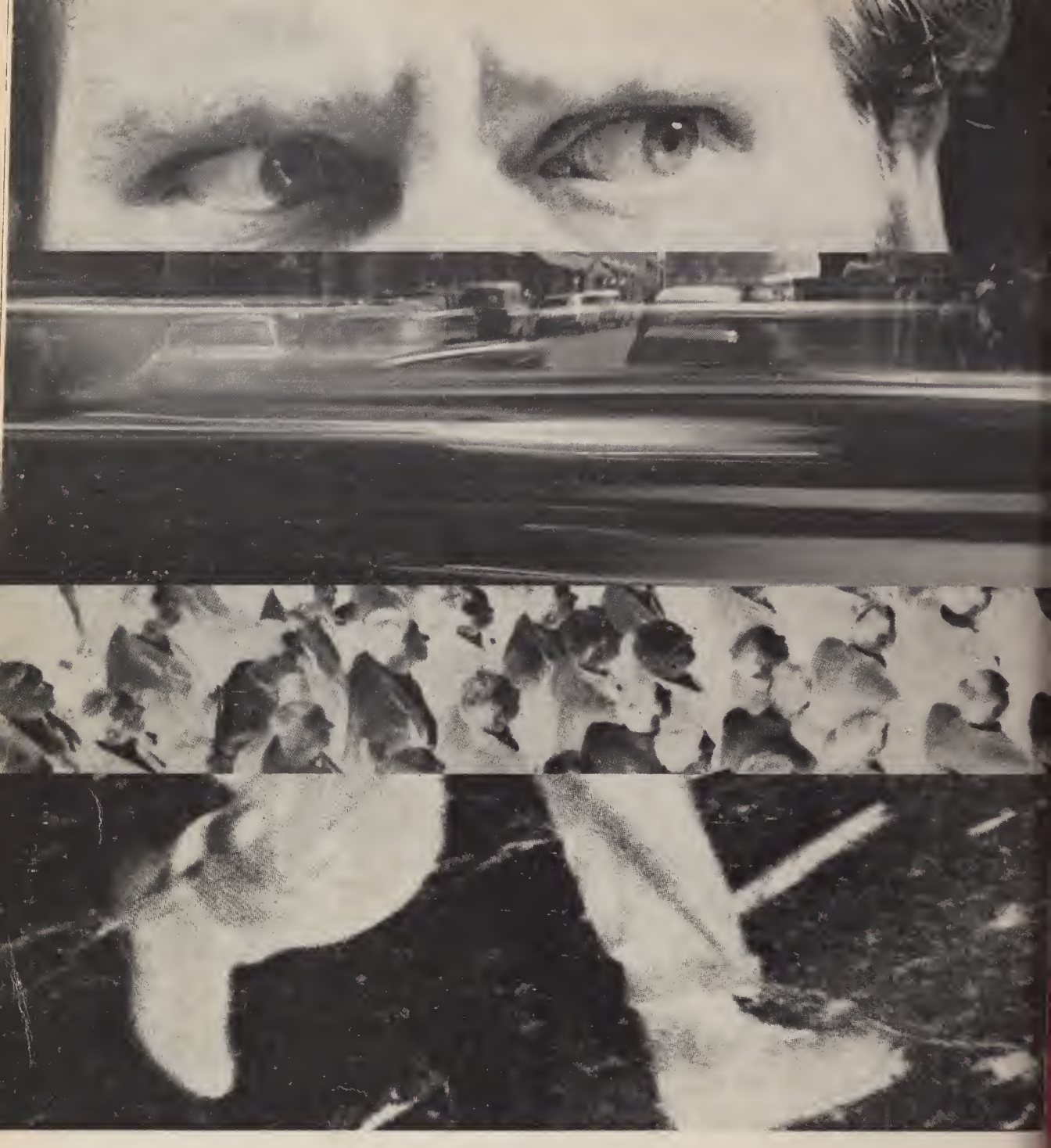
Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

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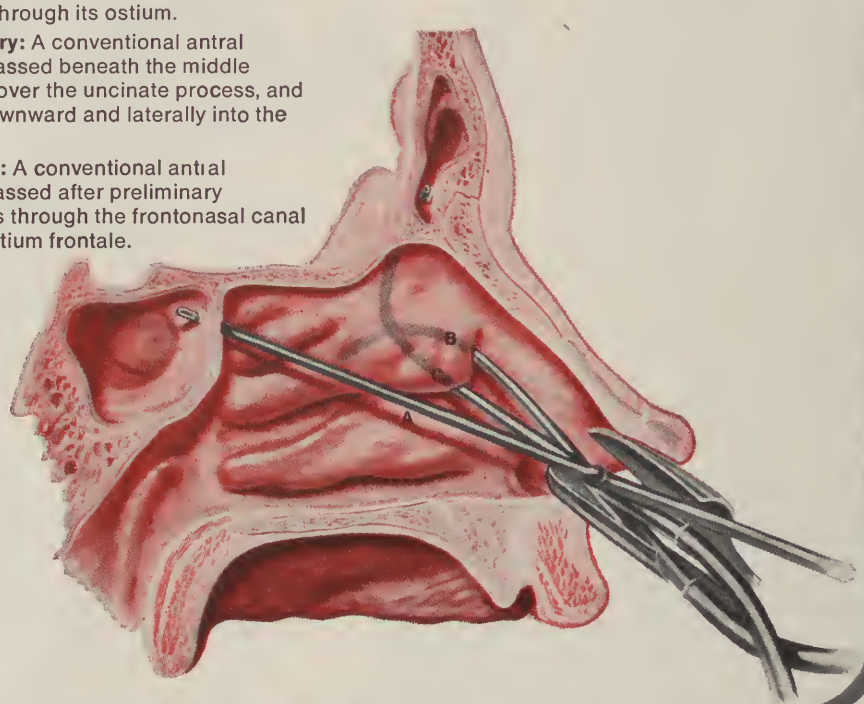
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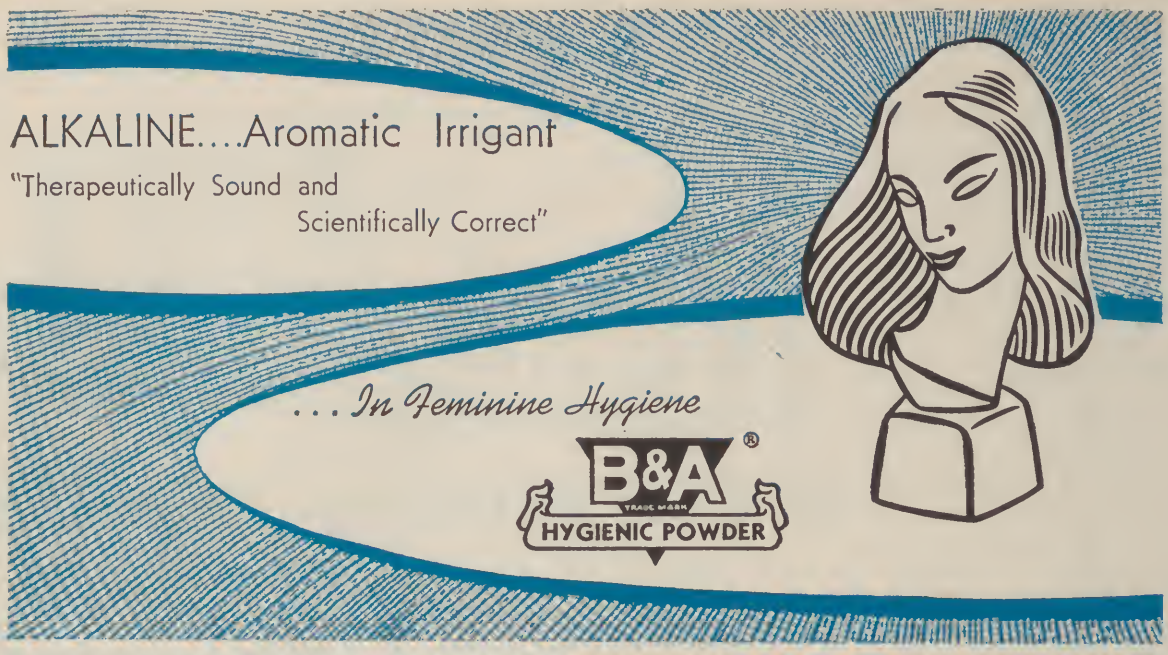
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(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

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Doctors take note...

March 2—7:30 PM—1211 Cathedral Street, Baltimore

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

"Digitalization in the Operating Room (illustrated), Marion A. Carnes, MD, Department af Anesthesia, University Medical Center, Lexington, Ky.

March 2-3—Medical College of Georgia, Augusta

FETAL AND MATERNAL WELFARE

A two-day cantinuing medical education sympasium. Panel discussions and didactic lectures stress clinical application to problems faced by the obstetrician and the general physician who does abstetrics. Infarmatian cancerning details of the program and registratian may be obtained by writing to the Department of Continuing Education, Medical College of Geargia, Augusta, Ga.

March 5—8:30 PM—1211 Cathedral Street, Baltimore

BALTIMORE CITY MEDICAL SOCIETY

"The Surgical Treatment of Pancreatic Disease," Robert W. Buxtan, MD, professor of surgery and head of the department, University of Maryland School of Medicine.
"Auto-immune Disease: Some Current Concepts," A. McGehee Harvey, MD, professor of medicine and directar of the department, The Johns Hapkins University Schaol af Medicine.
(Each speaker intends ta limit his address to one-half hour.)
A brief business meeting will fallow the scientific session.

March 6—8 PM—Shriver Hall, Jahns Hapkins University Campus

BALTIMORE AREA COUNCIL ON ALCOHOLISM

Governar Harold E. Hughes af Des Maines, Iowa, will speak at BACA's annual meeting, which will be open to the public. Governor Hughes, a recovered alcoholic, tells his story of how he conquered the disease of alcoholism 12 years aga, as published in *Laak*, October 6, 1964.

March 9—8:30 PM—1211 Cathedral Street, Baltimore

MARYLAND PEDIATRIC SOCIETY

Scientific papers by pediatric residents.

March 11—8:30 PM—1211 Cathedral Street, Baltimore

MARYLAND PSYCHIATRIC SOCIETY

Joint meeting with the Maryland Association of Private Practicing Psychiatrists.

March 22-26, The Conrad Hilton, Chicago
Golden Anniversary Session

AMERICAN COLLEGE OF PHYSICIANS

For program and registratian infarmatian, write ta American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

March 29—8:15 PM—1211 Cathedral Street, Baltimare
Jaint meeting with BCMS Sectian an Internal Medicine

MARYLAND SOCIETY OF INTERNAL MEDICINE

"Physiologic Basis for the Treatment of Refractory Shock," Arlie R. Mansberger, Jr., MD, assaciate prafessar of surgery, University of Maryland School of Medicine. Discussant: Leanard Scherlis, MD, associate professor of medicine, University of Maryland School of Medicine.

MEDICINE 1965
BCMS TELEVISION SERIES
WMAR-TV

Sunday, March 7—2 PM

"The Changing Image af the Dactor," Samuel Morrison, MD, Harry M. Rabinson, Jr., MD, Arthur G. Siwinski, MD.

Sunday, March 14—2 PM

"Anatomy Yau Should Know," Otto C. Brantigan, MD.

Sunday, March 21—2 PM

"STROKE," Erland R. Nelsan, MD.

Sunday, March 28—2 PM

"Bload Transfusions," Edward M. Rehak, MD, Charles S. Petty, MD, Alexander S. Townes, MD.



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As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

THREE DAYS TO MARK ON YO
APRIL
ANNUAL MEETING OF T
The Ale

Wednesday, April 21

Morning

House of Delegates Meeting

Afternoon

Charles S. Petty, MD
Assistant Medical Examiner,
State of Maryland
"Health Evaluation Tests"

Howard A. Patterson, MD
New York City
President-elect, American
College of Surgeons
"Surgical Management of Gastrointestinal Hemorrhage in Patients with Hereditary Hemorrhagic Telangiectasia"

Franklin T. Brayer, MD
Georgetown University
"The Population Explosion"

David C. Sabiston, Jr., MD
Duke University
"The Diagnosis and Treatment of Pulmonary Embolism"

Evening

Medicolegal Symposium
"The Changing Pattern of Medicolegal Action"

Thursda

Morning

E. Perry McCullagh, MD
Cleveland Clinic, Ohio
"Recent Studies in Hypopituitarism"

George S. Mirick, MD
Health Research Council, New York
"Viral Hepatitis"

Carl Muschenheim, MD
Cornell University
"The Treatment of Respiratory Insufficiency"

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pril 22

Afternoon

Lee Ramsay Straub, MD
Cornell University
"The Rheumatoid Hand"

Theodore R. Fetter, MD
Jefferson Medical College
"Urological Problems in General Practice"

Richard W. TeLinde, MD
The Johns Hopkins University
"Carcinoma-in-situ of the Cervix: Our Present Views on Diagnosis and Treatment"

Evening

RECEPTION AND PRESIDENTIAL DINNER
Sheraton-Belvedere Hotel
SPECIAL ENTERTAINMENT

Friday, April 23

Morning

Thomas B. Connor, MD
University of Maryland
and
R. Patterson Russell, MD
The Johns Hopkins University
"The Diagnosis and Treatment of Hypertensive States"

Thomas W. Mattingly, MD
George Washington University
"Effect of Aging on Diagnosis and Treatment of Heart Disease"

John H. Talbott, MD
Editor, *Journal of the American Medical Association*
"Gout: A Diagnostic and Therapeutic Challenge"

Afternoon

House of Delegates Meeting

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Committee on Program and Arrangements



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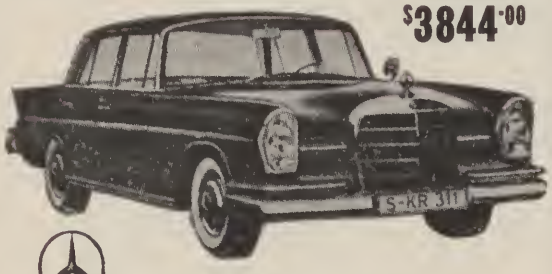
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THE TIME AND PLACE

Sally Ladin Ogden

The Greater Baltimore Medical Center is progressing rapidly, and many new innovations will be introduced to Maryland when this facility is completed on North Charles Street in Towson. Nursing units at the Greater Baltimore Medical Center will be new in size and in arrangement of rooms and corridors, offering many advantages for patients and medical staff.

Architects for the GBMC, Rogers, Taliaferro, Kostritsky, and Lamp, and Wilson, Christie, Niles, and Andrews, presented to the planners of the GBMC a new concept for nursing unit floor plan. The rectangle is reduced in length, and the rooms have been moved from their straight alignment into a staggered arrangement, wherein each group of four rooms shares a private entrance-foyer. This also serves as a clean utility center and storage space for all materials needed for those four rooms. Two rooms of each group have large windows facing the outdoors, while the two inside rooms have glass walls giving access to a private balcony-solarium. Utility rooms, preparation rooms, and pantry are placed in the center of the corridor with a nurses' station on either side. Two nurses' stations divide responsibility, so that every patient is less than half the former distance from care.

More than 90% of all adult rooms in the GBMC are private and designed for maximum efficiency and practicality. Since there is no corridor traffic past any door, there is no need for additional screening. Gone is the familiar dresser or bureau, yet all means to provide care and convenience are within reach of the patient. The bed, adjustable at will to height and contour, has an over-bed table. Built into the wall at the head of each bed will be access to oxygen and suction. Hot, cold, and ice water are within arm's length, built in a protective shelving space under which is adequate storage area for luggage or packages. Along the wall at the patient's side are open shelves for plants and reading material and closed shelving for medicines and private articles. A complete communications panel has been designed

for each patient room. This thin panel, which folds into the wall when not in use, can be extended over the patient's bed to make easily accessible electric control for patient-nurse intercommunication, radio and television control (television is standard in all rooms), lights and a curtain control, and the new trimline telephone with the built-in dial. A tall, slim closet is provided next to a floor to ceiling wall area of a porous material designed to hold cards and other items to be displayed. Each room has a private toilet and bath one and a half steps from the patient's bed. A combination table-lamp and chair complete the furnishings and equipment.

The GBMC's eye, ear, nose and throat wing will feature a corridor system new to the east coast. The central corridor will be for the exclusive use of professional personnel, making possible greater freedom and protection of nurses' stations, equipment, and drugs from visitor traffic. All visitor traffic is confined to a perimeter corridor. Each patient room in these wings will have two doors, one from the professional corridor and one from the visitor's corridor. This professional corridor arrangement will make medical care more efficient for medical personnel without inconvenience to visitors.

The design of future expansion projects at the GBMC will be influenced by the results achieved in these two nursing unit designs.

The Greater Baltimore Medical Center will open in September, 1965, as scheduled, according to the director, George H. Buck.

After many years of little or no new construction of hospitals and nursing homes in the greater Baltimore area, there has been a recent surge of activity in the development of new buildings with modern and up to the minute equipment to take care of the sick and convalescent.

The EDGEWOOD NURSING HOME, established in 1898 and located at 6000 Bellona Avenue, announced that it will break ground this spring for a new nursing home to care for 50 patients. Soon after this building is completed, an additional project will be undertaken to house 50 more patients.

The original home was opened by Mrs. Cora

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Carter in 1898. She operated the home until 1933, when her grandson, Robert Fusselbaugh, took over the business. Early in 1964, after the death of his father, Robert Fusselbaugh, Jr., became the director of this nursing home which has cared for many generations of Baltimoreans. The present home is a member of the Maryland Nursing Home Association and the American National Nursing Home Association.

One of Baltimore's most modern and complete nursing homes opened on December 6, 1964, at 6116 Belair Road. It is so new in design and so fully equipped for the care of the sick that a new name had to be coined to describe it. It is known as the CONVALESARIUM.

It is a multi-story, million dollar building, first in this area to be built with the help of the FHA. It looks more like a plush motel than a home for the convalescent. The home has such advanced features as remote control television, which enables a nurse to watch her patients from her nurses' station, and a well-furnished occupational and physical therapy room. The kitchen is complete with large walk-in refrigerator for frozen and perishable foods. The patients' dining room is cheerful with a magnificent crystal chandelier, and beautifully furnished sitting rooms provide color television. A nonsectarian chapel is open at all times.

DULANEY TOWSON NURSING AND CONVALESCENT HOME, 111 West Road, Towson, is now a contracting skilled nursing facility in the Maryland Blue Cross Plan's Senior Citizen program. This 115-bed institution becomes the twelfth nursing home in the state to participate in the special Blue Cross and Blue Shield programs for the elderly.

Subscribers to the high-level Senior Citizen program receive 70 days of in-hospital care and two days of care in Blue Cross participating nursing homes for each day of unused hospital care. For nursing home care, Blue Cross provides an allowance toward the institution's actual charges of up to 80% of these charges or $8 a day, whichever is less.

Dr. Alfred C. Kraft is the executive director of the DULANEY TOWSON NURSING AND CONVALESCENT HOME.

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EXECUTIVE SECRETARY'S NEWSLETTER

February, 1965

NUTRITION SEMINAR

The Faculty and the Dairy Council of the Upper Chesapeake Bay are sponsoring an all-day Nutrition Seminar on Thursday, March 18, 1965, at the Sheraton-Belvedere Hotel.

All phases of nutrition will be discussed and the session is open to all interested parties. Full details may be obtained through the Faculty office.

LICENSE REVOCATIONS

The licenses of Emanual Lebowich, M.D., and Dominick T. Rinaldi, M.D., have been revoked by the Board of Medical Examiners. Each has sixty days in which to file an appeal.

MARYLAND CHAPTER AMERICAN COLLEGE OF SURGEONS MARCH 13 MEET

Saturday, March 13, has been set for an outstanding session, to be sponsored by the Trauma Committee and the American College of Surgeons, Maryland Chapter.

An all-day session starting at 9:30 a.m., the program includes:

Transfusion Reactions: An Experimental Study with Therapeutic Implications

Influence of Trauma and Hemolysis on Hemorrhagic Shock

The Nature of Irreversible Shock

Prevention and Treatment of Acute Renal Failure Following Trauma and Hypotension

Resuscitation in Trauma: The Value of Central Venous Pressure Monitoring

Thrombosis and Thromboembolism

Serious and Fatal Football Injuries

NEWS NOTES

Israel H. Weiner, M.D., and G. Lee Russo, M.D., announce their association for the practice of Neurological Surgery at 1010 St. Paul Street, Baltimore.

The College of American Pathologists, under the new program on Accreditation of Laboratories, has made its first inspection in Maryland

and has certified the laboratory of Paul F. Guerin, M.D., and Watson Kime, M.D., as meeting the standards established for such accreditation.

REFERENCE COMMITTEE MEETING

The Reference Committee meeting has been scheduled for:

THURSDAY, MARCH 25, at 8:00 p.m.

in the Faculty Building.

Resolutions received at this time include:

1A/65 - Incorporation for Professional Persons (Wicomico County Medical Society)

2A/65 - Inclusion of Physicians on a Voluntary Basis under the Social Security System (George Vash, M.D.)

3A/65 - Return of Grant of the Tobacco Industry by the AMA (George Vash, M.D.)

Individual copies of the resolutions will be mailed to all delegates shortly. Members who are not delegates may obtain copies by contacting the Faculty office.

IMPORTANT NOTICE

Physicians receiving new drugs across state lines for use in clinical investigation must certify they will comply with "Drug Amendments of 1962."

This provision states physician will inform patient to whom drugs are being administered that drugs are being used for investigational purposes and will obtain consent of patient, or his representative, except where physician deems it unfeasible or contrary to best interests of patient.

John Sargeant
Executive Secretary

IT MAY BE LATER THAN YOU THINK . . .

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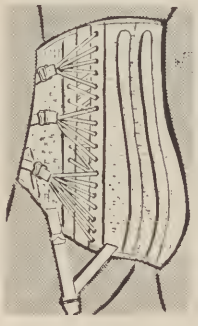
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References: 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (April 28) 1962. 2. Ivler, D., *et al.:* Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., *et al.:* Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax *19*:298, 1964. 9. May, J. R., *et al.:* Lancet *ii*:444 (Aug. 29) 1964. 10. Pines, A.: Lancet *ii*:445 (Aug. 29) 1964.

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SICK PEOPLE IN A TROUBLED WORLD

HOWARD A. RUSK, MD
Chairman, Department of Physical Medicine and Rehabilitation, New York University Medical Center

Improvement in the health of the people of this nation and the other developed parts of the world constitutes one of man's greatest achievements in the past half century. At this time, when the average age is advancing in the developed parts of the world, a new concept in the dignity of man and the worth of the individual is beginning to emerge in the underdeveloped areas of the world. This new concept is finding its expression in many instances in the extension of health services.

Peace is never a product of military force alone. Nearly two decades of the cold war have taught us that the political health of our own nation and of the world depends upon our economic health, and our economic health depends on the physical and mental health of our people.

I AM HONORED TO GIVE this second annual Jesse C. Coggins lecture in the field of geriatrics. It seems most proper that this be the topic of discussion, because Dr. Coggins was certainly an example of dynamic geriatrics. He truly lived till he died, because he was active until his last days, according to the history that I have read. He left in Mrs. Coggins' trust the operation of the institution that he had directed so many years, which, in his last years, was devoted to the geriatric and psychiatric problems of elderly ladies.

Whether we like it or not, geriatrics is a fundamental problem in the practice of medicine today, and you in this room are responsible for the problem. You are responsible, because with all the medical advances, especially in the last 40 years, man's life expectancy in this country has increased from an average of 46 years in 1900 to 71 today. Seven years have been added to the expectancy of every man, woman, and child in the United States in the last 15 years.

Our mutual friend and colleague, Dr. George Morris Piersol, described it succinctly when he told us our obligation. Dr. Piersol said, "We added years to life, and it is also our responsibility to add life to years."

I would first like to discuss a fundamental problem. This problem is the wasting of the most precious human resource that we have—the resource of wisdom. If there is a solution to this problem, I think that the leadership for it will have to come from medicine.

I wonder where the magic age of 65 came from. Why wasn't it 61, 63, or 68? The most logical reason that I can think of is that there

Jesse C. Coggins Fund Lecture on Geriatrics. A transcription of an extemporaneous presentation, May 7, 1964, at the 166th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

was a small company on the Eastern seaboard, a successful manufacturing company, that was having its annual meeting of the board of directors. The president, a very unpopular man, was not present at the meeting. Someone suddenly remembered that it was his 65th birthday. So they passed a resolution that there would be compulsory retirement at 65 in order to get rid of him.

Had Dr. Coggins retired at 65, you in Maryland would have lost 28 years of his fellowship and leadership. Had Winston Churchill retired at 65, it would have been the year before the battle of Britain, and I suspect that history might be written in a different vein than it is today.

I hear a lot of reasons for establishing a retirement date: We have to have a hard and fast rule. We can't hurt a lot of people's feelings by retiring some and keeping others on. It has to be the same for everybody. I noticed, however, that Mr. Thomas Watson didn't retire as chairman of the board of IBM until he was in his early eighties. Some of the company's greatest growth came during the last 15 years of Mr. Watson's life. Mr. Fred Ecker remained on the board of the Metropolitan Life Insurance Company until he died last month at 93; and I can go on down the list of leaders to demonstrate this point.

You can't tell me that a society, having furnished the resources to crack the atom, having so highly developed the field of electronics, and having so highly explored the stratosphere, cannot find the formula to be applied to an individual at any given age and not be capable of deciding either that it would be better for him to retire for his own safety or that of his fellow workers or that he should continue to produce—to utilize his wisdom. People are not born wise. Wisdom comes only with experience and experience comes only with time. I remember an event that illustrated this vividly to me.

There was a meeting of the Industrial War College in Washington during the first year of the Korean War. I was asked to speak to the College on "The Utilization of Elderly Workers and Handicapped People in Industry," because we were at a peak of employment and we didn't know how long this war would last or what our industrial requirements were to be. I talked about the same things that I am talking to you about this afternoon. Afterward the Major General, who was the commanding officer of the College, walked with me to my car. He said, "I was very much interested in what you said today. I started this War College. This was my idea. It was my baby. I raised it. No one else has ever commanded this college. Never has it been as important in our history as it is today. I just passed a perfect physical examination at Walter Reed last month, yet I am to retire four months from now at the same age that the average senator becomes eligible for committee chairmanship."

It may sound facetious, but it really gives one food for thought. In depth, this is a social problem and a medical problem. I think that those of us right here in this room, if we used the tools we have, through psychological and physical evaluation, could make recommendations on a totally non-partisan basis as to who should continue if they are needed and who should be retired.

This is a difficult program for us, because there isn't a vaccine, a pill, a potion, or a prescription for diet that we can give to help us solve the problem. We have to use social tools primarily, and these are more difficult. Everyone in this room has had patients who have reached the time of retirement, who retired unwillingly, whose whole lives have been devoted to their businesses, and all of a sudden the calendar turns and the door is closed. They are miserable. They go down the first day after retirement and have lunch with their friends, the next day with half the number, the next week with maybe one, and the next week everyone is busy.

You and I know that the rate of coronary thrombosis and cerebral vascular accident is tremendously high in this group—much above the average population. This is the clue, and I think the clue turns to this point. We all know the fundamental work of Cannon and Selye in stress and the part it plays in our life. I don't think stress is a good word in its general connotation, but that is the one in common use. Everyone in this audience, if he lived a good, full, happy life, has been fortunate enough to find his own stress point. However, everyone's stress point is different. If you go over, you break; if you stay under too far, you vegetate; but if you hit the middle point, your life is a happy one. It is like running a car with a battery. The major part is life, but one day, for some reason, you decide from now on to run the car with no battery. It can't be done.

What I think we have to do is to change stress to zest; it can be done, and you've seen it done.

But, again, this is a phase of preventive medicine that is more difficult than simply giving the injection of an immunizing serum or vaccine. Here again is evidence that the proper type of counseling can prepare your patient, who is probably your friend also, regarding the needs of retirement and attempt to stimulate an avocational interest months or years before, which will provide him zest. This may be staying on as consultant in his old business.

If you believe, or if business believes, that the principal problem is getting the "over sixty-fivers" out of the way in order to make room in the rising hierarchy for the younger people, it sounds like a weak excuse to me. If you take these individuals out of the general line of administration, with all its problems, and put them in a part of the business like the general staff of the military services, where they aren't in combat but where they make the plans and pass on the plans for combat, you have prevented a wasting of valuable human resources.

I don't care whether your patient raises rabbits, is a member of the Red Cross in his community, opens a little store, or does any one of a thousand different things as long as it gives him an interest and something to live for. There is evidence, not from the test tube or visible under a microscope, that such programs work—very simple programs.

The first one I saw was when I first came to New York in 1946 and visited a place known as the Hudson Center, a center for older people. It was then five years old and had 700 members. The story of its origin may be worth repeating. It was started because a bright-eyed observer found a clue. She was a social worker in one of the offices in the Bronx, and everyone in the office was distressed because they couldn't get any work done. There were streams of people coming by all day, the same people every day, with some kind of gripe: "My coffee was cold this morning." "I want to change my boarding house." "My shoes wore out a week before they should have." "My check was 14 cents below what it should have been this month." "Mrs. Smith said something about me and I want you to do something to her." Silly kinds of complaints, this worker observed, and subsequently told her colleague, "You know, I really don't think these people come here to gripe. I think they come because they have no place to go, for I've found that the longer I keep them waiting, the better they like it. Some of them bring their lunch and they want to stay and see me in the afternoon." So they called the ringleaders in and asked, "How would you like to have a club?" The answer was, "We'd love to have a club." "Well," they continued, "there are two vacant rooms over here in an old city building. We will fix up a club and you can organize it yourself." They said, "Fine." They organized it this way: They said, "In the first place we will elect officers every three months so everybody will have a chance to serve. Everyone will be on a committee." They had committees to make tea, committees to make coffee, to send out birthday cards, to visit the sick, and everybody was on one. They got an old secondhand pool table and a piano, and that was how they started.

As I said, I saw it five years after it opened, when there were 700 members. The oldest was 93, the youngest, 65, because they, too, took this magic number and forgot that age was physiological and not chronological. The average age was 76. By this time they had a big workshop, were open seven days a week, had two dances a month, and put on one play a month, which an old playwright wrote himself. There have been 11 weddings since the center opened, and it was a very happy program. But the interesting thing about it, medically, was that admissions to general hospitals for physical disease were 50% less in this group than they were in a similar age, social, and economic group that had no place to go. Visits to the clinic and the doctors' offices were 50% less in this group, and psychiatric breakdowns that required institutionalization were 90% less. Figuring the number of patients in the six-year period that ordinarily would have been admitted to psychiatric hospitals for senile psychosis, and what it did cost to run the center, which was 60 cents per week per patient, I calculated that the taxpayer had saved more than $40,000 a year in actual cash by this preventive program.

I am not here to spend any more time on sociological problems, but I do take this much time because I feel that this is a fundamental tool that we can use. There are more than 65 clubs in the country now. New York City has established more than 20, because they found it to be economically and socially sound. I would say it was also good practice medically.

We talked at noon today about some of the

problems of hospitalization of this age group and the inordinately high cost of hospitalization. We had an interesting experience on my service about 10 years ago, when I was given 100 beds at the Goldwater Memorial Hospital on Welfare Island to establish a geriatric rehabilitation training program. When we visited our newly acquired beds, we were a little surprised to find that there were 95 patients in them. So we took the occasion to find out why they were there.

There were only seven who needed continuing hospital care; the rest were there for social or economic reasons or had been forgotten. The average length of stay was four years, but one patient had been there since the hospital opened 15 years before. We were surprised and disturbed by this and by the fact that for the money spent these patients were not getting the best care. With the American Hospital Association, we did a survey of all the patients in the municipal hospitals, except obstetric, pediatric, tuberculosis, and psychiatric, to learn why they were there. We found 2,850 patients out of 10,300 who were there for social or economic reasons and not because they needed continuing medical care. I made a statement then to the effect that those who were in acute hospital beds would be better off if they were sent to the Waldorf, where they would have room service. It would be less expensive and far more pleasant.

You will meet patients in every hospital ward that you enter who fall into this category. They are always on the last bed; they are the old ununited fractures of the femur, the old strokes, the burned out arthritics, the Parkinsonisms; some of them have been there for years. Then we say rather piously, "Well, this is the best place. We give them good hospital care." Yes, we've kept them clean and well-fed, but they've lived in an atmosphere of sickness and death, and they're going out the back door to the morgue; or sickness and getting well, and they're going back into life again. But these people have remained behind. They are shushed when they play the little bedside radio because there are sick people in the ward. These people are not sick; they are disabled and need a different type of care.

We've organized a group in the New York hospital system that we call "homestead patients." A homestead is part of an operating general hospital or adjacent to it. Every homestead has a hospital, and if these patients get acutely ill, they are moved into the acute hospital. When their need is one of therapeutic recreation, their own clubs, self-government, stamps, art, and all kinds of activities are available to them. They are getting a little joy in life, and we find that they are better physically, they are much easier to handle, and the cost is unbelievably less. These patients can be kept in such a facility for $12-14 a day rather than $40 a day in an acute bed or $25 in a chronic bed, and they get better care at the same time.

Here again, I think, is the kind of thinking and planning we need to meet this ever-increasing problem, which now encompasses 18 million people in the United States over the age of 65.

So much for that. How about some of the medical problems of these people and what can you expect? I think that first we might discuss, briefly, the problem of stroke.

There are an estimated two million people in the United States who have strokes. We have just finished a survey of our first three thousand at Bellevue and at the Institute. We don't attempt any medical rehabilitation for people who have such severe brain damage that they can't remember what they learned yesterday, who have such severe cardiac damage that they can't take on added effort, or who have uncontrollable hypertension and an expectancy of less than six months. Aside from that, we take the run of the mill.

My own philosophy of rehabilitation is that we are a service-program, like the laboratory and the x-ray, to all of the specialties of medicine.

We now talk about the third phase of medical responsibility. The first is obviously prevention, the second, definitive care, and the third phase is that hiatus between the bed and the job. It's what happens to patients with a chronic disability or a chronic disease that requires a change in occupation. What happens after the fever is gone and the stitches are out? Patients are referred to us just like they are to any other service, and the relationship for the physician is the same. The patient remains a patient of his physician, and when the training period is over he goes back to his physician.

If he has problems in medicine, surgery, orthopedics, or whatever during his training, his physician takes his part in caring for these specific needs. This is a teamwork job involving doctors

and nurses trained in the techniques of rehabilitation, physical and occupational therapists, speech therapists, clinical psychologists, social workers, and so forth. This program is not just one to meet the physical needs of individuals. You have to meet, as well, the social, emotional, and vocational needs. Let me say it this way; it makes a little more sense: It's silly to take 120 days, which is our average training time, to teach a paraplegic to walk if his anxiety is so great that he won't go outside the house. If you meet this by sending him home to a third floor walk-up, where nobody has paid any attention to where he lives, you have done him no great service. If you meet the first three needs but don't help him take the next step to find the kind of job that he can do—within the limits of his disability but to the hilt of his ability—we have no more met our responsibility than if you sent your diabetic patient home, after a strict regime in the hospital, without dietary instructions and follow-up.

We have been working in this program long enough now to get some idea about what you can expect timewise. As I said, in this analysis of 3,000 stroke patients, the average age was 63; the average training time of inpatients was seven weeks. We were able to teach 87% to meet the needs of their daily living and return to noninstitutional life. Thirty-seven per cent went back to some kind of gainful work. As I said, the average training time for our paraplegics is 120 days. However, I am ashamed to tell you that it takes us twice as long to clear up the complications due to poor early management in the spinal cord injuries—bed sores, contractures, and kidney complications—than it does to train the patient. If we could just get them early, the cost and the time would be much less and the results would be much greater.

I'll talk about one other group in passing. If I had talked to you when I was here ten years ago and you had asked me what could be done for quadriplegics, I would have said, "Very little; it's very difficult." While this subject isn't in the geriatrics field, these patients will be geriatric problems one day because we have found that patients with cord injuries, both the paras and the quads, if adequately rehabilitated and if they follow basic directions on their braces or upright on a tiltboard at least two hours a day, and if they follow instructions about follow-up on genitalurinary problems, have a life expectancy quite similar to that of so-called normal people.

Our Institute has become rather the center for quads, though not from choice, because they are difficult to manage; no one else seems to want them. Most of them are young people in their early teens to early twenties, who've suffered from diving accidents, automobile accidents, and now the new horror, the rebound tumbling equipment. We've had eight broken necks at the Institute in the last two years resulting from the rebound tumbling device. I don't think anyone has any more right to open a public rebound tumbling center without an instructor to teach people how to use it and to observe them while they are using it, than one has a right to open a swimming pool with no lifeguard. I'm on a one-man campaign against this, and I have to get my little plug in.

We have just finished a follow-up study of the 365 quads we've seen at the Institute in the last five years, in relation to what they are now doing. Fifty-two per cent are either at work in competitive industry or back in college. Ten years ago there was only one college that had top flight advantages and would take these young people. That was the University of Illinois, where the program was first pioneered. Now I can give you a list of 50 good colleges where these individuals can be accepted and have a great learning experience.

We're asked sometimes, if an individual can't go back to work, why waste the time and the money and the effort to try to train him. Well, for the same reason that you treat these individuals with little cardiac reserve; you do everything that you can to preserve what they have. It gives them a better life. First, they deserve it; second and third, this is economically sound, because if you can teach patients to do for themselves, immediately you cut down the nursing costs, the attendant costs, and the complication rate.

I'm asked, too, and this came up at luncheon today, "Well, this is all right when you can have a big center, all the equipment, personnel, and what not; but what do you do when you don't have these resources?" We started our program in New York in 1947 in an old loft building with nothing. We started the Bellevue program in 1946 with only one qualified therapist and two doctors, and it grew because there was a demand for the service. If you are in a small community and you

don't have the center there immediately, you can still invest a certain number of dollars and a few weeks of time to train these patients and then set up a maintenance program in your own nursing home community. Let us imagine that you have four nursing homes of 100 beds in your community. If they're like ours, they're pretty bad. The beds are right next to each other; there is no recreation, no physical therapy—nothing for these patients to look forward to from day to day. With an absolute minimal cost, one physical therapist could be shared by three or four nursing homes. Somebody in recreation could come in three or four times a week on a shared basis. With an infinitesimal amount of money, in addition to what is presently being spent, their lives could be changed to interesting and dynamic ones; not as you would feel dynamism was, but certainly as they would feel it was by their past experience.

Rehabilitation works for a simple reason, but I think most of us have forgotten it. That reason is that, today, our society does not pay for strength. It pays for only two things: the skill in your hands and what you have in your head. The fastest runner in town can be too stupid to make a living. But I am afraid all of us tend to carry this image subconsciously—physical wholeness and ability being the same. It just isn't true.

We have trained 12 paraplegic doctors who had been cast on the professional junk heap, because someone forgot that feet were not a necessity in the practice of medicine. You practice medicine with a trained mind, your hands, your eyes, your ears, your voice, your personality, and your feeling for people. These young people have that in depth. In fact, they do a better job in medical rehabilitation than you and I can do, because they can treat and teach both by precept and example.

What is the future in this program? Until we find the answer to the enigmas of atherosclerosis, degenerating disease, debilitating disease, cancer, and all the other plagues to the human race that we have no answer for, the only approach, the only hope for these people, is a dynamic attitude using the tools that we have developed. There are many new things on the horizon which might interest you. As far as stroke is concerned, the most difficult problem that we encounter is aphasia. We know little about aphasia. In fact, we stopped talking about aphasia and we now talk about communication, because we find that we have patients who have only one or two words but who are perfectly clear mentally and communicate by gestures or intonation. There are 45 different breakdowns in the process of communication. We have found that by analyzing these in the computers (and we've just done our first 160 patients), we have a prognostic tool from which we can determine what to expect from speech therapy. The computers told us something else that interested us. We thought we were treating our aphasia patients in an ordinarily long period of time, but we found that the longer they were taught, the more they continued to learn. You can do it on a group therapeutic basis so that you won't have a one-to-one relationship with the speech therapists after you get to a certain point. But it is like education; you still continue to learn for what appears to be an indefinite period. This has been one of our greatest problems with our physician-patients with strokes.

Two years ago, in the spring, we had three prominent surgeons, all in their early sixties, from various parts of the country. They had right hemiplegia; all of them had recovered almost entirely, physically; and all three were totally aphasic. We have to do some thinking in the medical profession about how we can use the brains of these people. You can do it if they are in a wheel chair, you can do it if they are on crutches, you can do it if they have no hands; but if they can't speak, it is extremely difficult to find a place in our own profession where they can be used. It is going to take the thought of all of us if we are to find a solution for this. Our colleagues and I will tell you that the numbers are much greater than you think unless you sit in the place where they come, desperate for help, able in thought, but unable to communicate.

I was telling a little instance again at lunch today, about what had just happened to us in the last few weeks that illustrates what William Osler said here in Baltimore, just after the turn of the century—that medicine was and would always be an international program without ever knowing geographical barriers or international boundaries. I've had a chance to observe rehabilitation programs all over the world. We have trained some 600 young doctors from 60 countries who are now back in their own countries working in this program. Last summer I saw an interesting film made by Dr. Marien Weiss, at the Konstancin

Center, outside of Warsaw. In the film were a series of 20 patients with arteriosclerotic gangrene to which a plaster of paris cast, in lieu of a regular bandage, was applied on the operating table, together with a simple pegleg. The patients ambulated on the first day without pain. They left the hospital with their final leg within three to four weeks, which is about one-third of our time. Once the bandage is off and the stump is shrunk, you then fit the limb and refit it, all of which boils down to an inordinately long and expensive period.

My colleagues in the Veteran's Administration in New York, in the Surgical Department, and in our department, have just finished a small series of cases, far too small to hope that it is anything but maybe a guide line. The first patient, a 68-year-old diabetic, had gangrene requiring above-the-knee amputation. The limb was amputated with a long flap, and a special cast was made with a new elastic type of plaster of paris, which was applied directly to the stump. Before the operation, she had been measured for and supplied with a limb that was in the proper center of gravity, with a knee joint and an ankle joint. She was walking on the eighteenth hour after operation without pain, and she left the hospital on the seventeenth postoperative day. She had no phantom. She is one of four, the last of which was operated on the day before yesterday. They range from children, including one child with a BK amputation, and the others, all with the elderly group, with AK amputation and difficult circulatory problems. But, to us, they point to a whole new area of research possibility in design, in material, in theory, and hopefully in practice. If this is true, it means that we will cut down our hospitalization time by two-thirds. If this does solve the problem of phantom in a substantial number of these patients, it will mean a great deal, not only to us as physicians but also to our patients. We are also excited about the possibilities of research in the field of geriatrics with the hyperbaric chamber.

Observations have been made in Leyden and in Glasgow on failing circulation in the extremities and impending gangrene. Individuals have been put into the chamber with two to three atmospheres of pressure and the addition of oxygen. The limbs have been saved and maintained over a period of weeks, with a certain period of time spent each day in the chamber. Of course, the reason for this is that the oxygen is driven directly to the cell where it is needed.

What we're interested in with the hyperbaric program is whether we can put patients with brain damage in this atmosphere: can they learn more rapidly, and if they can learn, can they retain? There are some neurophysiologists who believe that around the basic area of infarction is a gray area of cells that are intact but are inert because of lack of oxygen. If these can be stimulated by a proper diet and a proper amount of oxygen over a continuing period, I don't think it's beyond the realm of possibility to feel a certain hope that we do have a new tool that can be used in the problems of brain damaged children and adults. We do know that refrigeration in cord injuries and animals, in our own studies, has tremendously increased the opportunity for recovery. Advances in chirogenic surgery, according to the engineers, give us reason to have new hope in this area. They say that it will not be impossible to make a device that could be implanted in the adenous injured cord and maintained at a temperature, within a fraction of a degree, for as long as one needed, without all of the problems of general body refrigeration. If this is true with the cord, there is no reason to think that it shouldn't at least be explored in the brain. All of this points to new eras of knowledge, exploration, and new hope in many of the problems that heretofore we had considered hopeless.

I'd like to close by reading six lines from the great scientist who had a stroke when he was 40 and did some of his greatest work in the twenty-odd years that he survived. He left this as his philosophy, which is certainly my philosophy, and I am sure it is your philosophy. He said it beautifully and simply in this way:

> Not to destroy, but to construct. I hold the unconquerable belief that science and peace will triumph over ignorance and war, that nations will come together, not to destroy but to construct, and that the future belongs to those who accomplish the most for humanity.

The author was Louis Pasteur.

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RESOLUTIONS

Important Notice for Component Medical Societies and Individual Members of Medical and Chirurgical Faculty

All resolutions or recommendations for presentation to the House of Delegates must be in the Faculty Office by WEDNESDAY, FEBRUARY 24, 1965, which is eight (8) weeks prior to the Annual Meeting, April 21, 22, 23, 1965. This is referred to in the following quote from the Faculty Bylaws:

> *. . . A Reference Committee of five members of the House of Delegates to which all Resolutions involving questions of Faculty policy, except those proposed by the Council or committees of the Faculty, shall be referred at least eight weeks prior to any regular session . . . of the House of Delegates. All such resolutions shall be reported to the House of Delegates with the committee's recommendations, provided that, with the sponsor's approval, the committee may revise any resolution.*

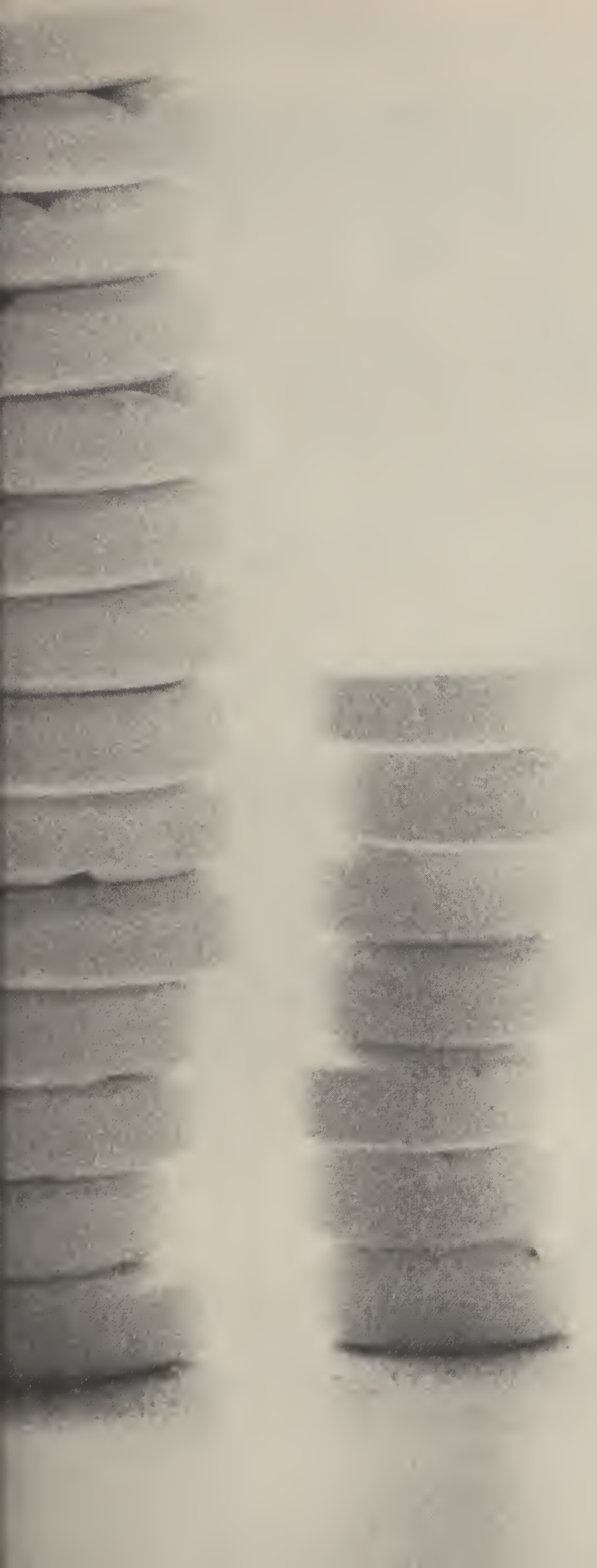
The meeting of the Reference Committee is open to all members of the Faculty in good standing, who may attend and express their opinions. Notice of the date and place of the Committee meeting will be sent to all members.

RESOLUTIONS for April, 1965, House of Delegates must be in the Faculty Office by WEDNESDAY, FEBRUARY 24, 1965

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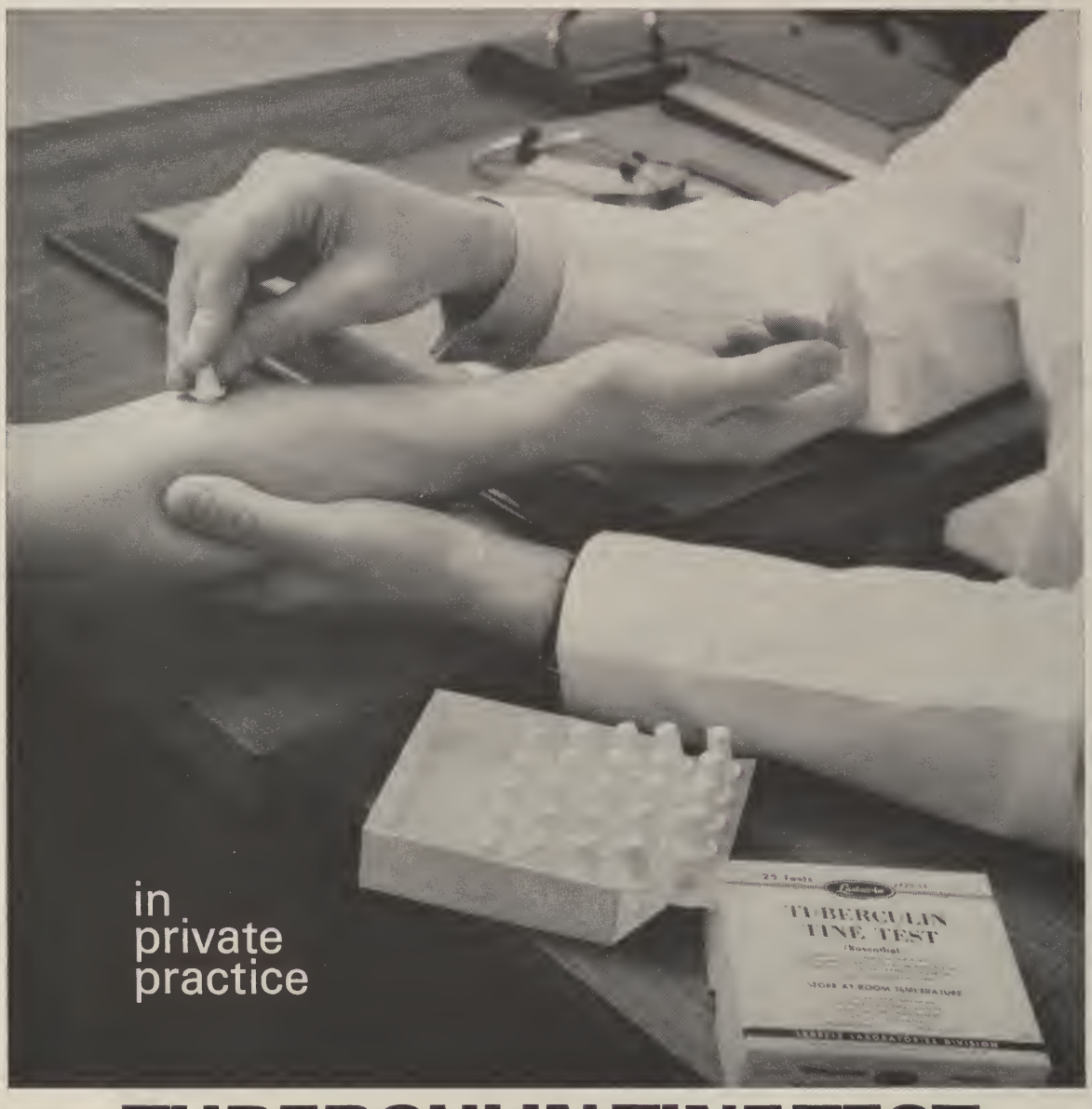
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COMPONENT MEDICAL SOCIETIES

ALLEGANY COUNTY



TUBERCULOSIS IN ALLEGANY COUNTY

ALLEGANY County maintains a continuous x-ray survey for possible new cases of tuberculosis and a recheck of positive cases. Twenty-six new cases of tuberculosis were confirmed by clinical examination and laboratory tests in 1964. Tuberculosis is increasing in Allegany County, as elsewhere, reversing the trend of past years.

An average of 10 to 20 patients are examined monthly by a chest physician in the Health Department. Emphasis is placed on home and hospital care, and each case is followed to a conclusion. No case is ever considered cured but is classified as arrested after temperature returns indefinitely to normal and x-ray and clinical and pathological findings are negative for five years. An average of 50 patients is continually under observation over a five-year test period.

It is not known exactly how many people in Allegany County have had tuberculosis at sometime in their life or now have an undiagnosed case. Most people in whom tuberculosis is found for the first time are in the later years of life.

For the past 15 years, the chest clinician of the Health Department has been **Ralph W. Ballin, MD.**

PERSONALS

New members of the Allegany County Medical Society are **Jose L. Valdes, MD, Americo L. Valdes, MD, Albert Marsh, MD,** and **Robert Dawson, MD.**

Robert Feddis, MD, Cumberland, attended a recent meeting of the American Academy of Orthopedic Surgeons in New York.

There is nothing in which people differ more than in their powers of observation.
—Idem

Leslie E. Daugherty, MD

ANNE ARUNDEL COUNTY

The Anne Arundel County Medical Society met on November 18 at Carvel Hall Hotel, Annapolis. Approximately 30 members attended.

After a social hour and dinner, a panel discussion was held on "The Battered Child," which proved to be of considerable interest to those present.

President **Samuel Borssuck, MD,** Annapolis, presided over the business meeting. The written report of the medical board meeting in October was presented. **James Hudson, MD,**

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Edgewater, reported for the Public Relations Committee concerning improved public relations in the area of coordinated medical coverage. A letter will be sent to the membership about this.

The announcement was made that the Medical and Chirurgical Faculty had requested reestablishment of the first aid room at the next session of the state legislature. It was unanimously voted that the Anne Arundel County Medical Society again organize and staff the first aid room at the Statehouse during the 1965 assembly.

Notice was given that February 24, 1965, was the deadline for filing of resolutions for the annual meeting of the Medical and Chirurgical Faculty.

Dr. Borssuck announced the appointments to Central Headquarters Committee.

Raymond Srsic, MD, Severna Park, informed the members of a questionnaire interview program organized in a possibly illegitimate manner or questionably unethical manner with reference to nutritional matters. He recommended that the members be on the lookout for these poll takers. No official action was taken on this matter.

Randall M. McLaughlin, MD



BALTIMORE CITY

At the annual business meeting, in December, the following officers were elected for 1965:

Arthur G. Siwinski, MD, president-elect; **Harry J. Connolly, MD,** vice president; **B. Martin Middleton, MD,** secretary; **William F. Pearce, MD,** treasurer; **George Govatos, MD, John F. Hogan, Jr., MD,** and **D. Frank Kaltreider, MD,** to the Board of Directors for two years.

Delegates for 1965 and 1966 are **Harry McB.**



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*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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William H. Mosberg, Jr., MD, was elected to represent the Society on the Faculty's Policy and Planning Committee, and Paul F. Guerin, MD, was nominated to the Faculty's Nominating Committee.

Elected to the Nominating Committee for 1965 were Edward M. Barczak, MD, John B. DeHoff, MD, W. Kenneth Mansfield, MD, and J. Donald Woodruff, MD.

Joseph D. B. King, MD

BALTIMORE COUNTY

A delicious Christmas buffet-luncheon at the Sheraton-Baltimore Inn helped to impart Christmas spirit to the members of the Baltimore County Medical Association and its guests. Louis Krause, MD, delivered a most interesting message on the genealogy of Christ.

Donald Roop, MD, chairman of the board of governors, reported on the December 1 board meeting. A letter has been sent to the Woman's Hospital from the board giving our endorsement to the opening of a GYN clinic in the Towson area provided that patients are accepted only on referral from their attending physician. The board also asked the Greater Baltimore Medical Center

to clarify its policy concerning staff privileges for members of our Association. The board further recommended increasing the salary of the executive secretary of the Baltimore County Medical Association to $1500.

S. J. Venable, Jr., MD, chairman of the Diabetes Detection Week Committee, announced that 700 Dreypak kits had been returned and 25 positive reactions for glycosuria were found.

Margaret Sherrard, MD, deputy county health officer, reported that premarital blood testing for syphilis was not productive in case finding and that states which have compulsory premarital tests have no reduction in morbidity.

Marie Rhine, MD, director of allergy in the Department of Pediatrics at The Johns Hopkins Hospital, described a study of children to be undertaken in the counties of Maryland. The Association endorsed this study.

Samuel Scalia, MD, of the Baltimore County Health Department, reported that in a program of x-raying food handlers in Baltimore County, about 19,000 persons have been x-rayed and 55 cases of tuberculosis were found, with 18 of these being active cases.

Mrs. Charles Williams was introduced as the new president of the Woman's Auxiliary at the Mt. Wilson Hospital.

NEW HEALTH OFFICER APPOINTED

Richard J. Potter, MD, of Dallas, Pa., has been appointed deputy state and county health officer in Baltimore County. He brings to his new assignment 13 years of experience in administration with the Pennsylvania Department of Health. He was regional medical director for an eight-county area in northeastern Pennsylvania, his native state.

Dr. Potter received his medical degree from Jefferson Medical College, Philadelphia, in 1948. He spent two years in private medical practice. In 1959 he was awarded a Master of Public Health degree from the University of Pittsburgh Graduate School of Public Health.

Dr. Potter replaces **William H. F. Warthen, MD,** who retired. Baltimore County Executive Spiro T. Agnew said, "Dr. Potter will bring to the high position of deputy state and county health officer a background of broad experience and dynamic approach which is admirably suited to the public health needs of Baltimore County."

Charles H. Williams, MD

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WICOMICO COUNTY

Seth H. Hurdle, MD, who retired in 1962 after 32 years as health officer of Wicomico County, recently received the coveted Annual Salisbury Award, which was presented at the monthly dinner meeting of the Wicomico County Medical Society, Inc.

This award is made "to that citizen of Salisbury, Maryland, who . . . has rendered a service which has been of the greatest benefit to the happiness, prosperity, intellectual advancement, or moral growth of the Community of Salisbury, and who is deserving of public recognition."

Dr. Hurdle was cited as having served the longest tenure of any health officer in the State of Maryland, during which time substantial progress in health and sanitation was made in Wicomico County. Examples of this are the lower death rates from diphtheria, whooping cough, typhoid, tuberculosis, venereal disease, and many other diseases. Dr. Hurdle also served as acting superintendent of the Peninsula General Hospital during World War II. He later helped as interim administrator of Pine Bluff State Hospital for tuberculosis during a period when no permanent administrator could be found, an arrangement so successful it continued for 10 years.

He actively promoted community campaigns for polio, heart disease, cancer, tuberculosis, mental health, and other projects. For the past two years he was chairman of the fund drive for the Chesapeake Bay Girl Scout Council, of which he is a member of the board.

He is a 32 degree Mason, a Shriner, Tall Cedar, and Elk and has served as an elder of the Wicomico Presbyterian Church. He has been commander of the Salisbury Power Squadron, has held most offices in the Salisbury Lions Club, and has twice been district governor of the 22nd District of that organization. He is currently president of the Maryland Diabetes Association.

Upon retirement from the Health Department two years ago, Dr. Hurdle began private practice in nearby Nanticoke, where a family doctor was badly needed.

In presenting the award, Mr. Ryder Jones of the Salisbury Award Committee said:

He is an unusual and wonderful person . . . simply because he has done all of these things . . . not for compensation, not for recognition, not for honors . . . but because of his intense desire to be of service to his fellow man, that this community may be a healthier, happier, and more pleasant place in which to live.

At the regular December meeting of the Wicomico County Medical Society, Dr. Hurdle was further honored by nomination for the annual Robins Community Service Award for Maryland.

Officers for 1965 were elected at the December meeting. They are: **Andrew C. Mitchell, MD,** president; **Charles Bagley, III, MD,** vice-president; **Marcus Stephanides, MD,** secretary-treasurer; **James P. Gallaher, MD,** and **William C. Morgan, MD,** delegates; **Frank E. Poole, MD,** and **H. Douglas Cooper, MD,** alternate delegates; **Harold N. Eccleston, Jr., MD,** Board of Censors.

Guests were **John Sargeant,** executive secretary of the Faculty, and his assistant, **Theodore Chilcoat,** who briefed the society on present and coming activities of the Faculty.

In a voluntary collection taken at the December dinner meeting, members of the Wicomico County Medical Society, Inc., joined with the medical staff of the Peninsula General Hospital in providing funds for Christmas gifts for inmates of the nearby Poplar Hill Correctional Camp.

With the cooperation of merchants and manufacturers, gift packages with a retail value of about $1.50 were wrapped for each of the 165 inmates, in appreciation for the voluntary blood donations made by them over the years to the blood bank of the Peninsula General Hospital. Inmates have regularly provided blood in emergencies and for indigent patients who can neither pay for blood nor find replacement donors.

A party was held at the Poplar Hill camp on December 28. Several doctors handed out the gifts to the prisoners. Cake and punch were served after the gifts were distributed.

Recent public relations activities of the Wicomico County Medical Society include December TV appearances by **Earl M. Beardsley, MD,** and **David W. Shave, MD,** and speeches by **H. Gray Reeves, MD,** chairman of the Speakers Bureau, before the Quota Club and at Salisbury State College. The latter was a debate on federal legislation to provide medical care for the aged.

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George S. Mirick, MD, is professor of medicine, New York University Medical College; scientific director, Health Research Council of New York City; associate professor of medicine, The Johns Hopkins University School of Medicine; and consultant to the surgeon general. He is also a member of the Virus Disease Commission, Armed Forces, and the Epidemiological Board.

Dr. Mirick was born in Washington, DC, received his AB at Princeton University and his MD at The Johns Hopkins University School of Medicine. He served an internship at The Johns Hopkins Hospital and residencies at Stanford University Hospital and Rockefeller Institute Hospital. A commander, MC, USNR, Dr. Mirick was attached to the US Navy Research Unit of the Rockefeller Institute and the Naval Medical Research Unit at Guam.

Since 1951, among other appointments, Dr. Mirick has been consultant in medicine at Fort Howard Veterans Administration Hospital. Between 1952 and 1958 he was physician-in-chief, Baltimore City Hospitals, and associate professor of medicine, University of Maryland School of Medicine. Dr. Mirick is a member of numerous medical societies and the author of approximately 60 publications.

ANNUAL MEETING OF MEDICAL AND CHIRURGICAL FACULTY

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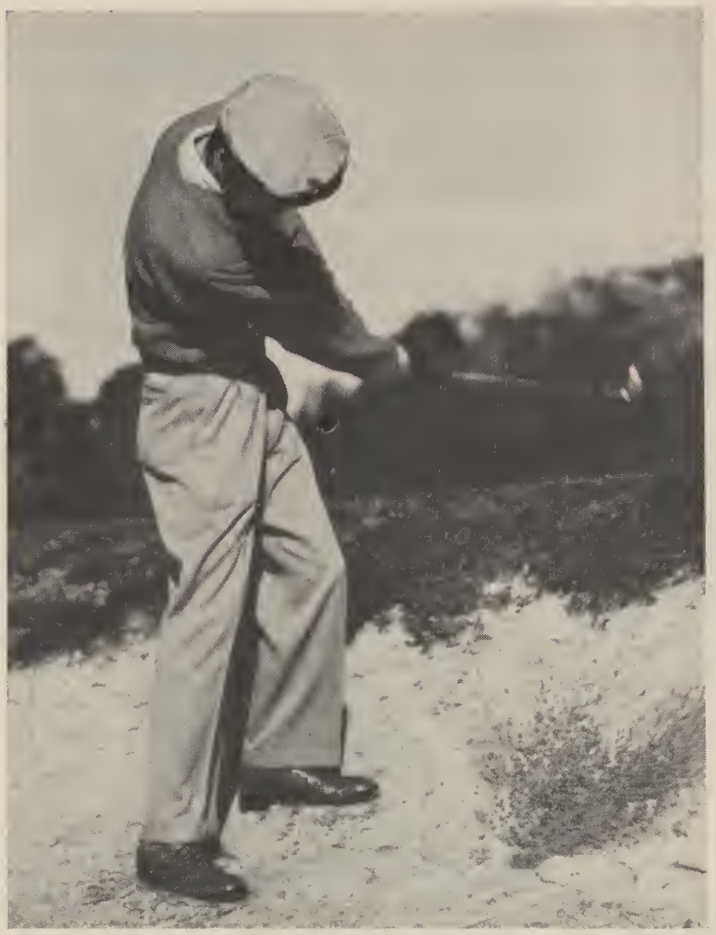
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THE MEDICAL CASE IN THE COURT OF LAW

WHEN A LEGAL CONTEST is based almost solely or even largely upon medical testimony there must be some better way to evaluate whether a defendant is guilty or innocent or whether a case should be judged for the plaintiff or for the defendant than for the facts to be presented to 12 laymen for a verdict.

Even by diligent study in preparation of a case, it is difficult for a lawyer to obtain enough information about the medical aspects to properly, adequately, and fairly present the case in the court room. The jury, on the other hand, has had no prior preparation, although with what the opposing attorneys will allow to be introduced they may acquire a smattering of information about a highly technical topic. If, then, the lawyers introduce a significant number of medical witnesses and the majority agree on the interpretation of the findings, all may be well; and the jury can be guided, at least in this regard, in reaching a verdict.

But if two expert witnesses are in direct contradiction to each other, a logical course of action for many jurors might be to throw out the testimony of both and simply rely on the rest of the testimony, which, of course, defeats the entire purpose. Then, if one expert witness is handsome or fatherly or kind, he is likely to have a more impressive effect upon a jury than somebody who is younger or more forceful or in any other way less than the ideal witness. In such a case, when the crucial medical testimony is in conflict, the juror may decide that because one man looks older, or speaks more glibly or looks more fatherly or has a more prestigious position that he must be correct. Such an interpretation would, of course, be ridiculous.

It would appear to be unreasonable and grossly unfair to either party in the case to expect the average jury to understand the details of medical diagnosis and the nuances—or even many of the principles—of pathological physiology and anatomy and medical and surgical care, let alone the medical points of disagreement of the medical experts. What could be more absurd than to expect lay people to be given a limited medical education in the court room, then to be presented with only certain facts, then to be carefully guided by the opposing lawyers, and finally to have to perhaps "read between the lines" and make a decision in a situation where ranking medical experts may be unable to agree? Surely this is not fair to *anybody* involved in the case!

Were the medical experts themselves allowed free rein in the court room to prepare the case and guide the medical aspects of it and present it impartially to the jury in a way in which the jury might hope to understand, this would be one thing; but this is not the case. The medical expert is at times confounded by the minutiae which are picked up by the lawyers and blown up out of all proportion, during which their apparent intent is not really to elucidate the case but to discourage, anger, contradict, or otherwise discredit the expert witness, all of which is acceptable legal procedure. But medical testimony or any other highly technical testimony cannot tolerate these deviations; it cannot be smothered, camouflaged, obscured, or belittled by the almost endless regulations of the court room, for too much is at stake—a life, freedom, reputation, money, etc.

It would seem that the most reasonable way to determine the outcome of a principally medical case would be to have a jury composed of physicians (perhaps selected or appointed by the local medical society or medical specialty groups) and to have the case presented in such a way

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that it is a medical problem and not one of legal gymnastics with medical overtones. Perhaps one could have a dual jury, one in which there were 12 lay people to consider and decide the lay problems and another composed of a number of selected physicians (for whom this would be a prestigious appointment) to hear, consider, and judge the medical aspects. This could apply to any other highly technical situation which the average layman cannot reasonably be expected to understand—except superficially—even with hours or days of court room education. Other technical fields could have their appointed specialists for these special juries in the same manner.

Perhaps this editorial is a cry in the wilderness and perhaps no improvement is possible. But with the increasing number of court cases, the increasing number of medical-legal actions, the increasingly overburdened court rooms, anything which could be done to improve the situation should be given serious thought. To say that such a concept is unthinkable and at complete variance with the American legal precepts is tantamount to admitting that many cases are going to be tried before people who have only the slightest concept about the basic problems of the case or the ability to fairly judge the case on its merits.

It seems reasonable that if physicians were not belittled, browbeaten, or subjected to impugnations regarding their integrity they might be more willing witnesses. Many physicians are reluctant to go to court because of the delays, insults, and tiresome repetition of often pointless questions. Would it not be possible to try medical cases before medical juries? If this could be worked out or something similar to this could be arranged, much of the involved medical preparation of the jury could be dispensed with and the cases either summarily presented and dispatched; or, at least, they could be settled more fairly than many are settled today.

W. B. King, Jr., MD

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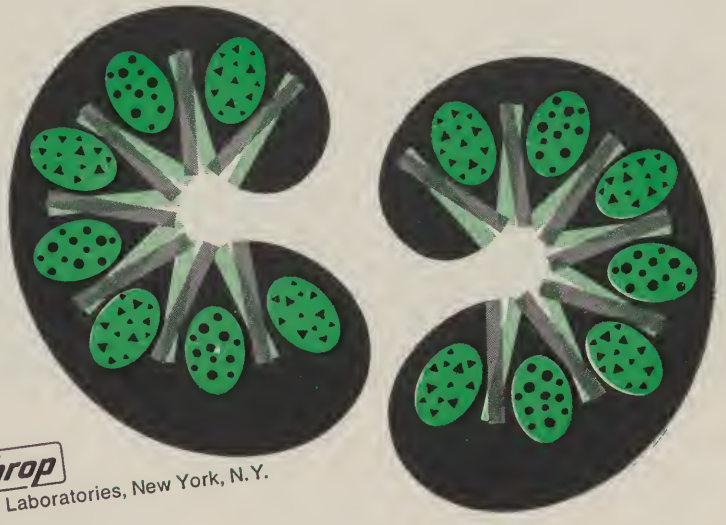
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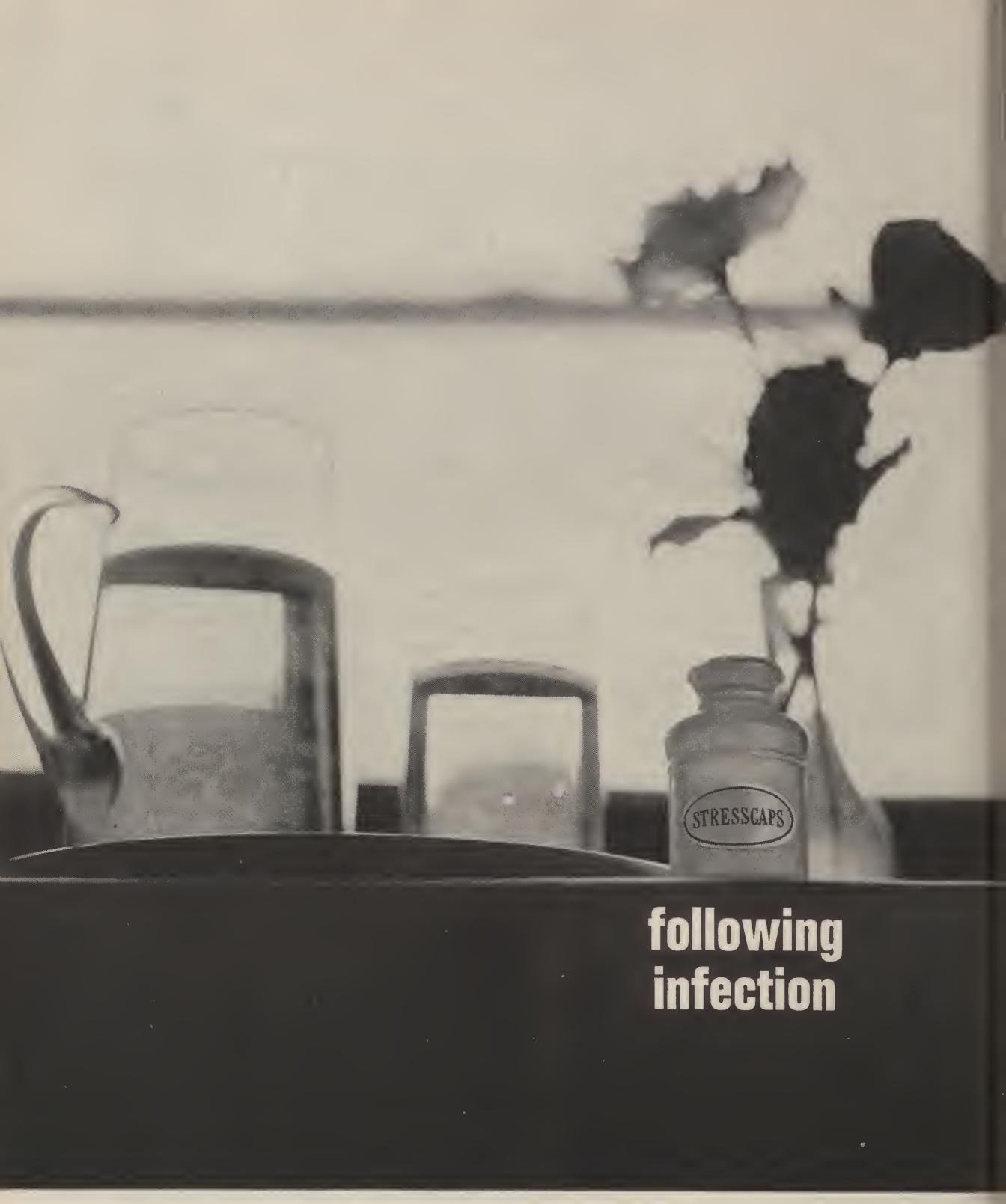
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The Heart Page

George C. Roveti, MD—*Editor*

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Recent Advances in the Metabolism of Digitalis Glycosides

LUIS FELIPE GONZALEZ, MD

The value of cardiac glycosides in clinical medicine is well established. Their method of action, blood and tissue distribution, and excretory pathways, however, have been conjectural. The lack of readily available and sensitive chemical methods has significantly hindered the elucidation of their metabolic fate. In the last decade, isotope dilution techniques, dialysis, and chromatographic studies have lead to more definitive and specific identification of the various glycosides in the circulating blood, body organs, and waste products.

The initial breakthrough in the determination of glycoside action *in vivo* was accomplished by Okita and coworkers at the University of Chicago. They were able to study the metabolic fate of digitoxin obtained from digitalis plants grown in a $^{14}CO_2$ atmosphere. This group was able to show that a significant amount of a digitoxin dose is excreted early and that the major organ of excretion is the kidney. An enterohepatic circulation for this glycoside was demonstrated.

Because of the potential hazards associated with ^{14}C, the data obtained were mostly limited to single dosages in severely ill or preterminal patients. Nevertheless, the material collected has withstood the test of time, newer techniques, and a multidiscipline of other radioactive glycosides and investigators.

In the last five years, tritium-labeled digoxin, digitoxin, and ouabain have been used more extensively. The improved radiochemical purity of these preparations and the use of tritium as a label has resulted in numerous studies in man. Most clinical investigators have used ^{3}H-digoxin. The advantages of this preparation have been described elsewhere. The published material indicates that the glycoside (^{3}H-digoxin) is rapidly excreted (T $\frac{1}{2}$, 33 hours), that blood levels decline rapidly after intravenous administration, and that tissue levels remain elevated for hours. *In vivo* material collected at the time of surgical procedures utilizing cardiopulmonary bypass attest to the validity of the data collected under a less sophisticated clinical setup. The highest concentration of the glycoside has been found in the kidneys, heart, and liver. Of these, the heart does not have a higher concentration per gram of tissue nor a higher concentration per organ.

Radiochromatographic identification of the isotope-labeled material excreted in the urine attests to the stability of the isotope-label and to the excretion of the unaltered glycoside. In rats, unpharmacological and malignant doses of this glycoside have resulted in the identification of small amounts of digoxigenin. These experimental studies forfeit the specific advantages of radioisotope labeled drugs, namely, to be able to use drugs in quantities within the routinely recommended clinical dosages.

More recently, histoautoradiograms have shown the widespread distribution of the isotope particles on the x-ray film. This may be the result of using exceedingly high doses of the drug in acute experiments. Others have been able to localize isotope particles more specifically within the cell in relation to various muscle bands.

Significant advancements in the metabolic fate of cardiac glycosides have taken place in the last decade. Further elucidation is anticipated with the use of electron microscopy and the study of human material in a clinical setup in which ^{3}H-digoxin is substituted in multiple rather than single doses for its non-labeled counterpart under careful followup at our larger clinical centers.



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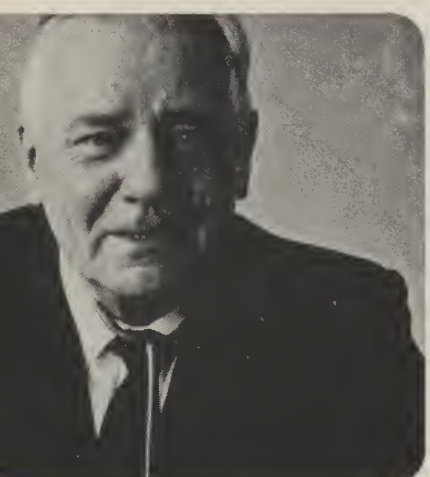
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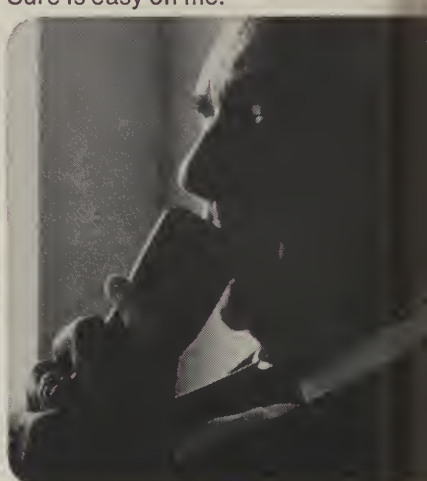
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BARIUM SWALLOW IN EVALUATION OF CHRONIC OR RECURRENT PNEUMONIAS IN INFANCY AND CHILDHOOD





Fig. 1

Aspiration of barium into the larynx and trachea (arrows) demonstrated in a five-year-old boy with familial dysautonomia. (Selected frames from cine-esophagram.)

OLGA M. BAGHDASSARIAN, MD
and
WILLIAM M. GATEWOOD, MD

From the Department of Radiology, Johns Hopkins University and Hospital.

RECURRENT OR PERSISTENT PNEUMONIA in infancy and childhood poses a difficult problem of diagnosis and management in pediatric practice. Access of ingested material or regurgitated gastric secretions into the respiratory tree is often overlooked as a causative mechanism. Barium swallow with fluoroscopic observation, and cinefluorography if available, is essential in evaluating conditions leading to aspiration. This examination should be performed routinely in any infant or child in whom persistent or recurrent pneumonic infiltrations present a clinical problem.



Fig. 2

Spillage of opaque material into the trachea in a six-month-old retarded, spastic girl with extensive chronic bilateral pneumonia.



Fig. 3

Aspiration of contrast material in a one-day-old infant suspected clinically of having tracheo-esophageal fistula.

Conditions demonstrable by barium swallow and cine-esophagram are:

A. Defective Swallowing Mechanism

1. Micrognathia
2. Riley-Day syndrome
3. Brain damage and neurologic deficit
4. Idiopathic incoordination in the newborn

B. Direct Tracheo-esophageal Communication
   1. Congenital H-type tracheo-esophageal fistula
   2. Postoperative recurrent fistulae
C. Esophageal Obstructions Resulting on Overflow Aspiration
   1. Congenital and acquired esophageal stenoses
   2. Achalasia
   3. Vascular rings

DEFECTIVE SWALLOWING MECHANISM

Hypopharyngolaryngeal incoordination resulting in aspiration of contrast material at the hypopharyngolaryngeal level often is seen in association with micrognathia as well as in patients with Riley-Day syndrome.[2, 3]

Micrognathia is a rare congenital deformity consisting of an abnormally small mandible. It is a feature of the Pierre-Robin syndrome when glossoptosis and cleft palate are associated.[5] The infant with micrognathia feeds with difficulty and has repeated aspiration pneumonias. Contrast examination of the swallowing mechanism shows spillage of opaque material into the trachea at the laryngeal level. The opaque material may also be regurgitated into the nasopharynx and thence aspirated.

The Riley-Day syndrome, resulting from autonomic dysfunction, is characterized by defective lacrimation, excessive perspiration, inconstant hypertension, cyclic vomiting, emotional instability, and recurrent pulmonary infections. Cineradiography of the esophagus demonstrates overflow of the barium into the larynx and trachea during swallowing (Fig. 1). The amount of fluid aspirated increases with progressive swallowing, suggesting that fatigue of the deglutition function may play a part. The aspirated contrast material or food does not provoke coughing, and the patient is unaware and undisturbed by this occurrence.

Occasionally, infants with brain damage or nonspecific neurologic deficit may have widespread bronchopneumonia, and radiographic examination may demonstrate aspiration (Fig. 2).

Pharyngeal incoordination resulting in aspiration may also be encountered in the newborn.[1] This temporary incoordination, lasting for the first few days of life, may be severe enough to be confused clinically with tracheo-esophageal fistulae. Occasionally, a temporary gastrostomy may be required to prevent continued massive aspiration.[4] The cause is unknown, but it may be related to immaturity (Fig. 3).

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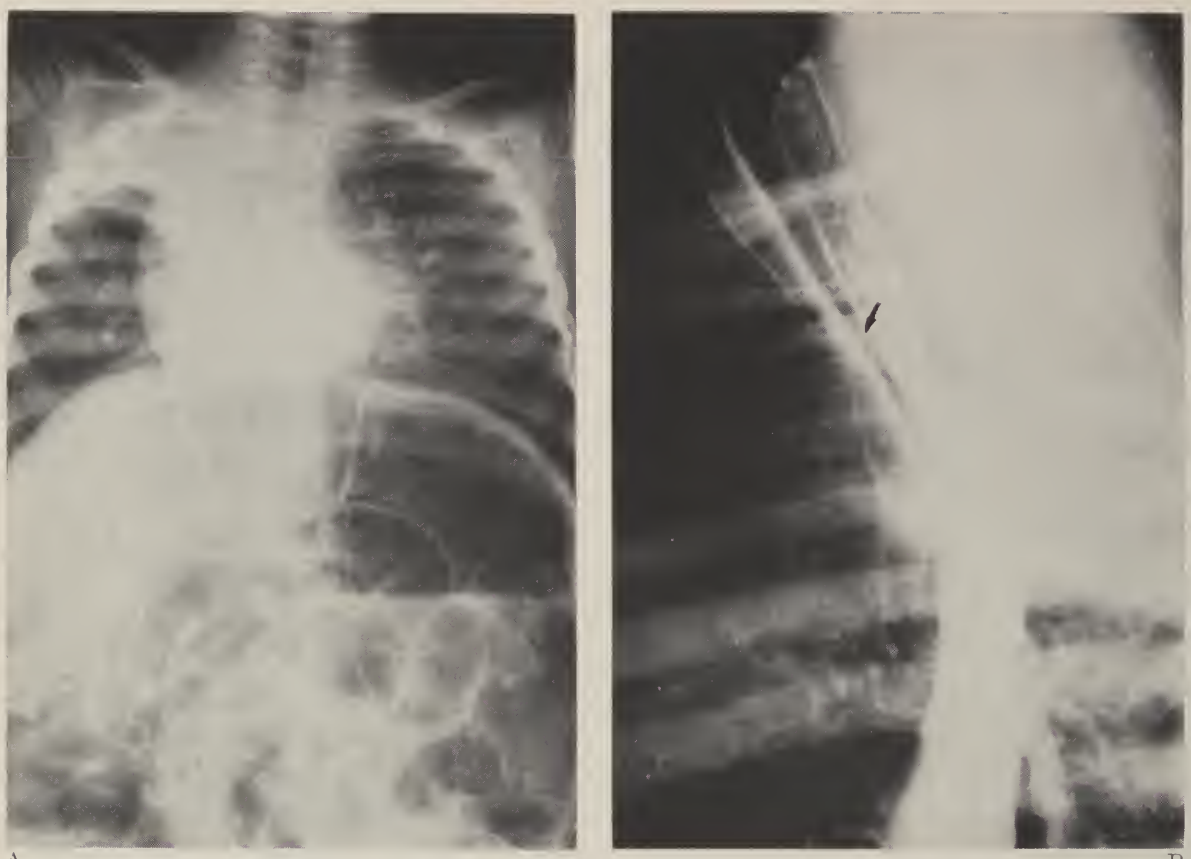
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Fig. 4

A. AP roentgenogram of chest and upper abdomen in a one-year-old boy with H-type tracheo-esophageal fistula, demonstrating extensive bilateral infiltration, right upper and lower lobe atelectasis, and marked abdominal distention. B. Spot film demonstrating the tracheo-esophageal communication.

DIRECT TRACHEO-ESOPHAGEAL COMMUNICATIONS

The presence of extensive brochopneumonic infiltrations in infants and young children should suggest the possibility of an H-type tracheo-esophageal fistula. This type of fistula may occur as an isolated congenital malformation or may be a postoperative complication of a repaired esophageal atresia and tracheo-esophageal fistula. Children with this condition have recurrent espisodes of widespread bronchopneumonia and respiratory distress. A striking feature is the marked distention of the stomach and bowel resulting from the free flow of air from the trachea into the stomach (Fig. 4A). Radiographic demonstration of these fistulae is inconsistent because the tracheo-esophageal communication is not constantly patent, and repeated examinations may be necessary. The infant must be placed in the prone oblique position, since the congenital trachea-esophageal fistulae are directed anteriorly and superiorly (Fig. 4B). Many consecutive swallows must be observed, because the fistula may only be fleetingly demonstrated.

Infants with persistent or recurrent pneumonia after repair of esophageal atresia and tracheo-esophageal fistula should be re-examined. Postoperative recurrences of tracheo-esophageal fistulae are usually found at the site of the anastomosis.[6]

ESOPHAGEAL OBSTRUCTIONS WITH OVERFLOW ASPIRATION

These conditions are a rare cause of recurrent pneumonia. They include congenital esophageal stenosis, acquired strictures, vascular ring, and achalasia. Achalasia is seldom encountered in infancy and early childhood.[3] These obstructions cause dilatation of the esophagus, stagnation of food and fluid, and resulting overflow spillage of



Fig. 5

Eighteen-month-old boy with caustic esophageal stricture (A, B). Cinefluorography demonstrates spillage of opaque material into the trachea (arrows).

esophageal content into the larynx and trachea (Fig. 5).

REFERENCES

1. Avery, M. E.: *The Lung and Its Disorders in the Newborn Infant.* Philadelphia: W. B. Saunders, 1964, pp. 141-143.
2. Baker, D. H.: Chronic Pulmonary Disease in Infants and Children. *Radiol. Clin. N. Amer.* 1:519-537, 1963.
3. Girdany, B. R.: The Esophagus in Infancy: Congenital and Acquired Diseases. *Radiol. Clin. N. Amer.,* 1:557-569, 1963.
4. Harris, G. B. C.: The Newborn with Respiratory Distress: Some Roentgenographic Features. *Radiol. Clin. N. Amer.,* 1:497-519, 1963.
5. Nelson, W. E.: *Textbook of Pediatrics,* ed. 8. Philadelphia: W. B. Saunders Company, 1964, p. 678.
6. Sieber, W. K. and Girdany, B. R.: Tracheo-esophageal Fistulae without Esophageal Atresia—Congenital and Recurrent. *Pediatrics* 18:935-942, 1956.



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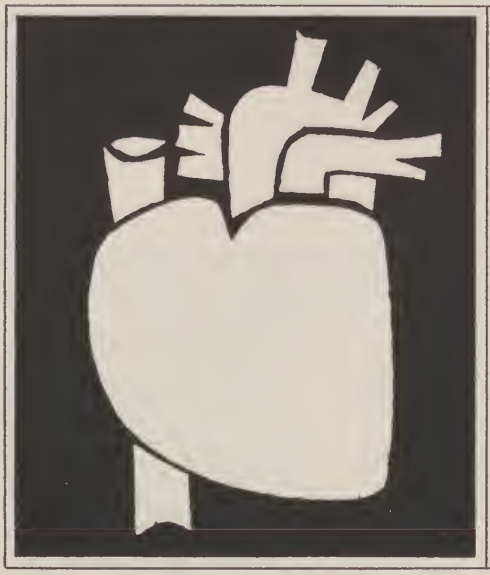
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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CML-4087

Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

News of the Alcoholism Field

IN A LETTER ADDRESSED to every member of the Medical and Chirurgical Faculty of the State of Maryland, Isadore Tuerk, MD, commissioner of mental hygiene, offers "'consultation regarding the admission or progress" of an alcoholic patient by the professional staff of the alcoholic rehabilitation unit of the state hospital serving the region in which the patient lives. He suggests that the physician wishing such service call either the medical director or the social worker of the unit.

Dr. Tuerk also appeals for cooperation by community physicians in the medical management of alcoholics:

> We believe our hospital programs for alcoholics are making progress, but we know very well that because of the *chronic* nature of alcoholism, an in-patient program depends for its effectiveness on out-patient follow-up. We look to the state's practicing physicians to provide the continuity of interest and treatment alcoholic patients must have if they are to maintain the sobriety achieved in the hospital.

PERSONNEL NOTES

Jorge Lopez-Sosa, MD, has accepted the position of medical director of the Crownsville State Hospital Alcoholic Rehabilitation Unit. Dr. Sosa, an internist, is associated with Church Home and Hospital in Baltimore.

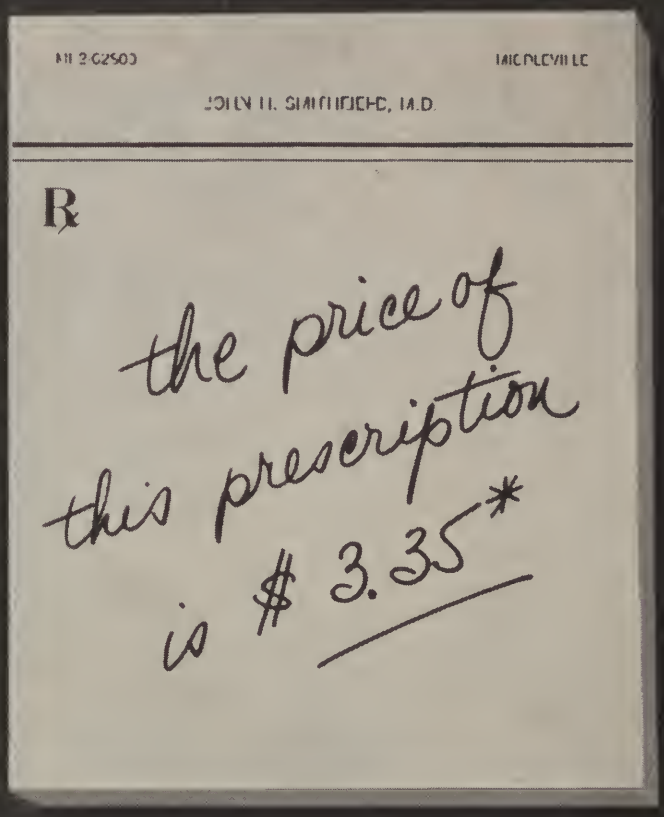
Francisco Piqueras, MD, medical director of the Springfield State Hospital Alcoholic Rehabilitation Unit, returned to Spain last month. His successor has not yet been named, but S. Cammarata, PhD, is acting as unit program director.

NEW ALCOHOLISM CLINICS

Caroline and Cecil Counties have new alcoholism clinics operated by their respective health departments. The Caroline County Clinic, directed by Edwin Riley, MD, health officer, meets Tuesday evenings, 8 to 10 P.M., in the health department building in Denton. The Cecil County Clinic meets Thursday evenings, 6 to 9 P.M., in Elkton. It is under the general direction of Health Officer John M. Byers, MD.

Both alcoholics and relatives of alcoholics may attend the clinics. Appointments can be made by calling the appropriate county health office, and referrals by practicing physicians are welcome.





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*Average prescription price, 1963. National Prescription Audit, R.A. Gosselin, Dedham, Mass.

REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

FUNCTIONAL EVALUATION: THE BARTHEL INDEX

A simple index of independence useful in scoring improvement in the rehabilitation of the chronically ill

FLORENCE I. MAHONEY, MD
AND
DOROTHEA W. BARTHEL, BA, PT

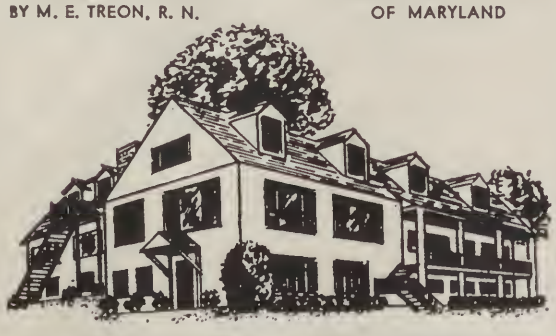
SINCE 1955, THE CHRONIC DISEASE HOSPITALS in Maryland (Montebello State Hospital, Deer's Head Hospital, and Western Maryland Hospital) have been using a simple index of independence to score the ability of a patient with a neuromuscular or musculoskeletal disorder to care for himself, and by repeating the test periodically, to assess his improvement. The Barthel Index (BI) has also been taught to many nurses, who have been helpful in evaluating patients prior to admission to these hospitals and after discharge.

The values assigned to each item are based on the time and amount of actual physical assistance required if a patient is unable to perform the activity. Full credit is not given for an activity if the patient needs even minimal help and/or supervision, ie, if he cannot safely perform the activity without someone present in the room with him. Because of the time required to attend an incontinent patient and since he is not socially acceptable, continence was weighted heavily.

Environmental conditions may affect the patient's score. If he has special requirements (other than the usual home setting), his score will be lower when they are not met. Examples are: doorways wide enough for easy access by wheelchair; all rooms on the same level if he cannot walk; bed, toilet, and wheelchair at the same height; ramps instead of steps into the house; a wheelchair that meets his needs if he cannot walk; grab bars at the toilet and tub.

To be more valuable, an explanation of special environmental requirements should accompany the BI of each patient when these are indicated.

Each patient's BI is scored at the beginning of treatment in the Rehabilitation Service (PM&R), at intervals during the course of his rehabilitation, and at the time of maximum benefit. In this way, it is possible to determine how well and how rapidly he has progressed toward independence. Sometimes improvement does not show up because the presence of another person

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may still be required even though he does not actually give physical assistance. Usually lack of improvement in the BI after a reasonable period of treatment indicates poor potential for rehabilitation.

BARTHEL INDEX

	With Help	*Independent*
1. Feeding (if food needs to be cut up = help)	5	10
2. Moving from wheelchair to bed and return (includes sitting up in bed)	5-10	15
3. Personal toilet (wash face, comb hair, shave, clean teeth)	0	5
4. Getting on and off toilet (handling clothes, wipe, flush)	5	10
5. Bathing self	0	5
6. Walking on level surface (or if unable to walk, propel wheelchair)	0*	5*
*score only if unable to walk		
7. Ascend and descend stairs	5	10
8. Dressing (includes tying shoes, fastening fasteners)	5	10
9. Controlling bowels	5	10
10. Controlling bladder	5	10

A patient scoring 100 BI is continent, feeds himself, dresses himself, gets up out of bed and chairs, bathes himself, walks at least a block, and can ascend and descend stairs. This does not mean that he is able to live alone: he may not be able to cook, keep house, and meet the public, but he is able to get along without attendant care.

DEFINITION AND DISCUSSION OF SCORING

1. **Feeding**
   10 = Independent. The patient can feed himself a meal from a tray or table when someone puts the food within his reach. He must put on an assistive device if this is needed, cut up the food, use salt and pepper, spread butter, etc. He must accomplish this in a reasonable time.
   5 = Some help is necessary (with cutting up food, etc., as listed above).
2. **Moving from wheelchair to bed and return**
   15 = Independent in all phases of this activ-

ity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.

10 = Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.

5 = Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if he transfers with a great deal of help.

3. Doing personal toilet

5 = Patient can wash hands and face, comb hair, clean teeth, and shave. He may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own make-up, if used, but need not braid or style hair.

4. Getting on and off toilet

10 = Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. He may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, he must be able to place it on a chair, empty it, and clean it.

5 = Patient needs help because of imbalance or in handling clothes or in using toilet paper.

5. Bathing self

5 = Patient may use a bath tub, a shower, or take a complete sponge bath. He must be able to do all the steps involved in whichever method is employed without another person being present.

6. Walking on a level surface

15 = Patient can walk at least 50 yards without help or supervision. He may wear braces or prostheses and use crutches, canes, or a walkerette but not a rolling walker. He must be able to lock and

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unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)

10 = Patient needs help or supervision in any of the above, but can walk at least 50 yards with a little help.

6a. Propelling a wheelchair

5 = If a patient cannot ambulate but can propel a wheelchair independently. He must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. He must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking.

7. Ascending and descending stairs

10 = Patient is able to go up and down a flight of stairs safely without help or supervision. He may and should use handrails, canes, or crutches when needed. He must be able to carry canes or crutches as he ascends or descends stairs.

5 = Patient needs help with or supervision of any one of the above items.

8. Dressing and undressing

10 = Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.

5 = Patient needs help in putting on and removing or fastening any clothing. He must do at least half the work himself. He must accomplish this in a reasonable time.

Women need not be scored on use of a brassiere or girdle unless these are prescribed garments.

9. Continence of bowels

10 = Patient is able to control his bowels and have no accidents. He can use a suppository or take an enema when

necessary (as for spinal cord injury patients who have had bowel training).

5 = Patient needs help in using a suppository or taking an enema or has occasional accidents.

10. Controlling bladder

10 = Patient is able to control his bladder day and night. Spinal cord injury patients who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.

5 = Patient has occasional accidents or cannot wait for the bed pan or get to the toilet in time or needs help with an external device.

A score of 0 is given in all of the above activities when the patient cannot meet the criteria as defined above.

The advantage of the BI is its simplicity. It is useful in evaluating a patient's state of independence before treatment, his progress as he undergoes treatment, and his status when he reaches maximum benefit. It can easily be understood by all who work with a patient and can accurately and quickly be scored by anyone who adheres to the definitions of items listed above. The total score is not as significant or meaningful as the breakdown into individual items, since these indicate where the deficiencies are.

Any applicant to a chronic hospital who scores 100 BI should be evaluated carefully before admission to see whether such hospitalization is indicated. Discharged patients with 100 BI should not require further physical therapy but may benefit from a home visit to see whether any environmental adjustments are indicated. Encouragement by family and others may be necessary for a patient to maintain his degree of independence.



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Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

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MENTAL RETARDATION
Methods of Diagnosis and Some Recently Described Syndromes

B. W. RICHARDS, LRCP, MRCS, DPM
Caterham, Surrey, England

A doctor confronted with a patient who may be mentally retarded is faced, in general, with three diagnostic problems. First, is there reduction of intelligence or are non-intellective factors interfering with the use of such intelligence as the child has? Deafness, especially partial deafness, or poor vision sometimes impair school performance. Second, the degree of retardation, and upon this diagnosis the prediction of the child's future depends: whether the child will ever be trainable, educable, or employable. Third, granted a child is mentally retarded, what is the diagnosis?

Diagnoses may be classified as follows:

1. Mental retardation. Symptomatic; should be qualified as to degree of subnormality.

2. Mental retardation with associated physical symptoms, such as hydrocephalus or spastic paralysis. Although the diagnosis is narrowed down, nevertheless there are many causes for each of these groups and different patients with the same symptoms may have different diseases.

3. Mental retardation of a specific type, such as the Sturge-Weber syndrome. This condition can be diagnosed clinically. Unlike a symptom such as spastic paralysis, which may be brought about in half a dozen different ways, the Sturge-Weber syndrome has one cause (highly unprobable for more than one).

4. Mental retardation of a specific type with known etiology. Mongolism, due to a chromosome anomaly, and true microcephaly, due to a rather rare, recessive gene, both are included.

5. Mental retardation of specific type and known etiology and with some knowledge of how the cause leads to the effect. Examples are gargoylism, isoimmunization, and phenylketonuria (PKU). Gargoylism is due to a recessive gene which causes a disturbance of lipid metabolism. Isoimmunization is usually caused by a Rhesus-positive fetus and a Rhesus-negative mother relationship. PKU is due to a rare recessive gene leading to a missing enzyme.

To diagnose with as much detail and precision as possible, much help can be gotten. Chromosome anomalies should be suspected in any condition characterized by multiple congenital malformations. Buccal smears enable a diagnosis of Klinefelter's or Turner's syndrome. Chromatographic

Abstracted from Canad Med Ass J, Vol 89, No 20, p 1024.



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screening permits detection of inborn errors of metabolism. Some biochemical tests are simple to do in practice, eg, the Phenistix test for PKU; the spot test for presence of mucopolysaccharides in urine (gargoylism).

X-ray studies are diagnostically valuable in diseases like the Sturge-Weber syndrome. Air studies, such as air-encephalography and ventriculography, may assist in the diagnosis of cortical atrophy and the detection of the site of obstructions in hydrocephalus. An electroencephalogram may provide evidence of an epileptic tendency or of a focal lesion. An examination of white blood cells can be useful to show, for example, the presence of vacuoles or granules in the lipidoses. Radioiodine studies are necessary to study the inborn errors of metabolism. On the other hand protein-bound iodine values may suggest cretinism.

Although not convenient to carry out extensive investigations on every case in practice, it is imperative to make use of those tests which may be indicated by clinical findings.

(The author concludes the article with three recently described syndromes.)

BALTIMORE CITY HEALTH DEPARTMENT

ROBERT E. FARBER, M.D., M.P.H.
COMMISSIONER

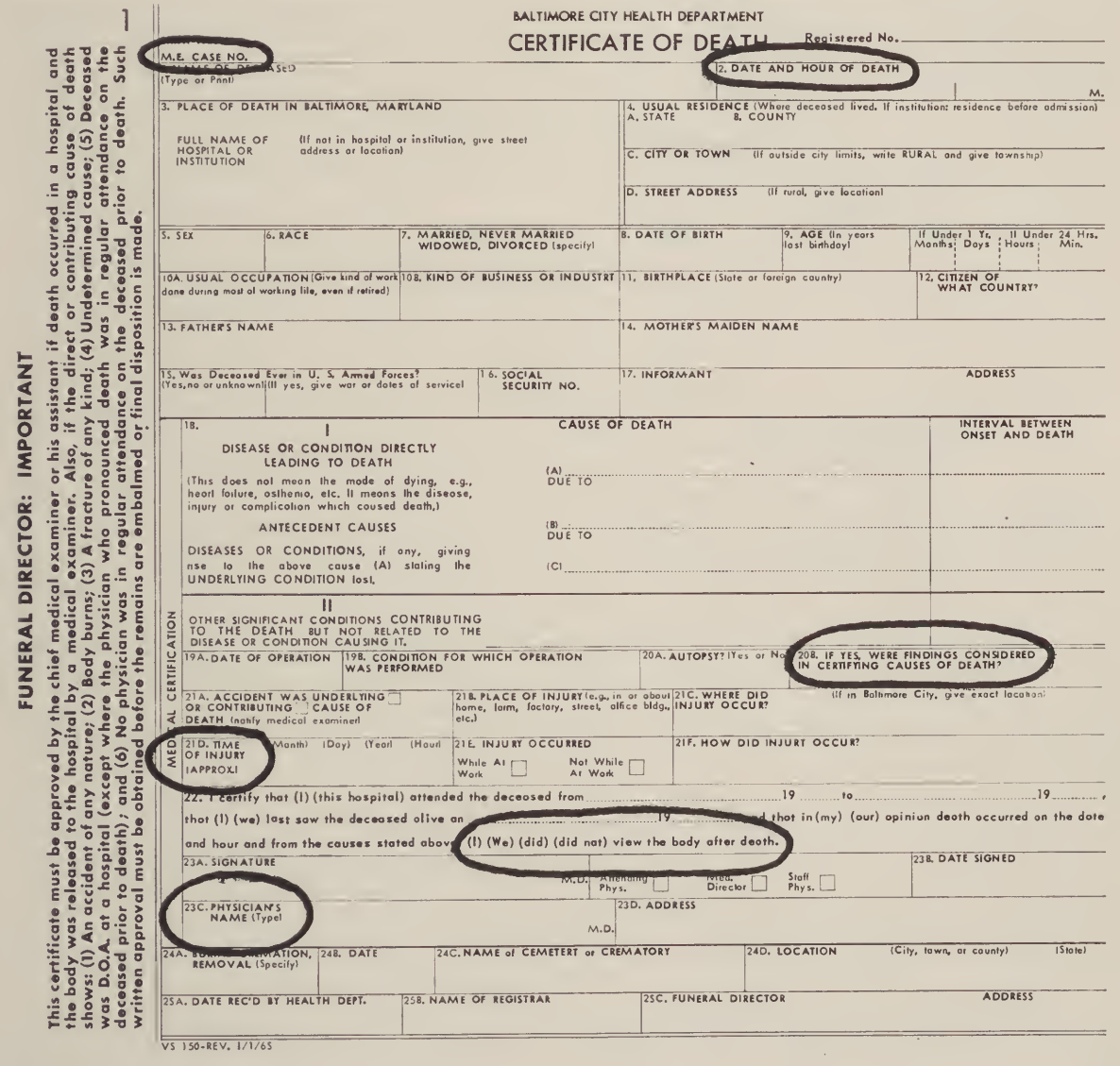
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Death Certificates Revised

ON JANUARY 1, 1965, THE BALTIMORE CITY Health Department put into use revised death and fetal death certificates. A number of changes have been made in the informational aspects of the forms, as recommended by the Public Health Conference on Records and Statistics and the Chief Medical Examiner of Maryland. The



1

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

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(Type or Print)

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FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS

MEDICAL CERTIFICATION

18. I — CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — (A) DUE TO

ANTECEDENT CAUSES — (B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. — (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE | M.D. Attending Phys. ☐ Medical Director ☐ Staff Phys. ☐ | 23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) | 23D. ADDRESS | M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS

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1. ☐ First trimester
2. ☐ Second trimester
3. ☐ Third trimester
4. ☐ Unknown

Complications of Labor
0. ☐ None
1. ☐ Placenta Previa
2. ☐ Abruptio Placentae
3. ☐ Prolapse of cord
4. ☐ Anomaly of cord
5. ☐ Breech presentation
6. ☐ Other malpresentations
7. ☐ Contracted pelvis
8. ☐ Other dystocia

Operative Procedures
0. ☐ None
1. ☐ Low forceps
2. ☐ Midforceps
3. ☐ Trial forceps
4. ☐ Cesarean section
5. ☐ Breech extraction
6. ☐ Internal version and extraction

Congenital Malformation Of Infant
☐ No. ☐ Yes
Describe

Mother Was
☐ Private Physician's Patient
☐ Hospital Service Patient
☐ Other (Specify)

For RCND Use
In case of multiple births, write Reg. No. for each mate.
Liveborn:
Stillborn:

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF FETAL DEATH

REGISTERED NO.

1. NAME OF FETUS (IF GIVEN)
2. DATE OF DELIVERY (MONTH) (DAY) (YEAR)
3. SEX OF FETUS — MALE ☐ FEMALE ☐ UNDETERMINED ☐
4A. THIS DELIVERY WAS — SINGLE ☐ TWIN ☐ TRIPLET ☐
4B. IF TWIN OR TRIPLET, THIS FETUS WAS DELIVERED — 1ST ☐ 2ND ☐ 3RD ☐
5. PLACE OF DELIVERY IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
6. USUAL RESIDENCE OF MOTHER (WHERE DOES MOTHER LIVE?)
A. STATE B. COUNTY
C. CITY OR TOWN (IF OUTSIDE CORPORATE LIMITS, WRITE RURAL AND GIVE TOWNSHIP)
D. STREET ADDRESS (IF RURAL, GIVE LOCATION)

FATHER
7. NAME A. (FIRST) B. (MIDDLE) C. (LAST)
8. RACE
9. AGE (AT TIME OF DELIVERY) _____ YEARS
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
11A. USUAL OCCUPATION
11B. KIND OF BUSINESS OR INDUSTRY

MOTHER
12. MAIDEN NAME A. (FIRST) B. (MIDDLE) C. (LAST)
13. RACE
14. AGE (AT TIME OF DELIVERY) _____ YEARS
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
16. PREVIOUS DELIVERIES TO MOTHER (DO NOT INCLUDE THIS FETUS)
A. HOW MANY CHILDREN ARE NOW LIVING?
B. HOW MANY CHILDREN WERE BORN ALIVE BUT ARE NOW DEAD?
C. HOW MANY OTHER CHILDREN WERE STILLBORN (BORN DEAD AFTER 20 WEEKS PREGNANCY)?

17. CAUSE OF FETAL DEATH
I. DIRECT AND ANTECEDENT CAUSES (ENTER ONLY ONE CAUSE PER LINE)
DIRECT CAUSE — STATE FETAL OR MATERNAL CONDITION DIRECTLY CAUSING FETAL DEATH (DO NOT USE SUCH TERMS AS STILLBIRTH OR PREMATURITY.) (A) _____ DUE TO
ANTECEDENT CAUSES — STATE FETAL AND/OR MATERNAL CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST. (B) _____ DUE TO (C) _____
II. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER WHICH MAY HAVE CONTRIBUTED TO FETAL DEATH, BUT, IN SO FAR AS IS KNOWN, WERE NOT RELATED TO DIRECT CAUSE OF FETAL DEATH.

I HEREBY CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD.
18A. ATTENDANT'S SIGNATURE
M.D. ☐ OTHER (SPECIFY) MIDWIFE ☐
18B. DATE SIGNED
18C. ATTENDANT'S NAME (TYPE OR PRINT)
19. ADDRESS (STREET, CITY, TOWN, OR STATE)
20A. FIRST DAY OF LAST NORMAL MENSES
20B. WEIGHT OF FETUS GRAMS OR LBS. OZS.
20C. WHEN DID FETUS DIE — BEFORE LABOR ☐ DURING LABOR OR DELIVERY ☐ UNKNOWN ☐
20D. AUTOPSY — YES ☐ NO ☐
21A. BURIAL ☐ CREMATION ☐ REMOVAL ☐ RELEASED TO HOSPITAL ☐
21B. DATE
21C. NAME OF CEMETERY, CREMATORY OR HOSPITAL
21D. LOCATION (CITY, TOWN, COUNTY) (STATE)
22. DATE REC'D BY HEALTH DEPT.
23. NAME OF REGISTRAR
24. FUNERAL DIRECTOR ADDRESS

A CERTIFICATE OF FETAL DEATH MUST BE EXECUTED WITHIN 24 HOURS FOR EVERY FETUS DEAD AT BIRTH IF THE PERIOD OF GESTATION IS 20 OR MORE WEEKS, OR IF THE PERIOD OF GESTATION IS UNKNOWN AND THE FETUS WEIGHS 400 OR MORE GRAMS.

V3 140—REV. 1/1/65

changes as noted in the accompanying illustrations are as follows:

1. The Certificate of Death now calls for a combined date and hour of death as one item (item 2), information on autopsy (item 20B), the approximate time of injury (item 21D), an indication as to whether or not the body was viewed after death by the certifying physician (item 22), the typing of the name of the attending physician (item 23C), and an item "M.E. Case No." at the top of the certificate.

2. The Certificate of Fetal Death is changed to a three part form. It now calls for the name of the attending physician to be typed (item 18C). A statement governing the registration of fetal deaths appears in the lower part of the certificate.

The attention of physicians is directed to a new feature in both death certificates. These certificates, which are multicopy forms, now have one copy which serves as an automatic burial-transit permit. In the Certificate of Death the automatic burial-transit permit is the fourth or last copy (yellow). In the Certificate of Fetal Death the automatic burial-transit permit is the third or last copy (yellow). It is no longer necessary for funeral directors to obtain a special burial permit from either the Bureau of Vital Records or the Police Department.

The changes have been made after consultation with the Maryland State Department of Health and the Chief Medical Examiner. Eventually they will lead to uniformity in birth and death registration procedures throughout the state.

There is no significant change in the Certificate of Live Birth.

Robert E. Farber, MD
Commissioner of Health

State of Maryland

Department of Health William J. Peeples, MD, MPH, Director

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Highlights

HEALTH AND EDUCATION COOPERATIVE ECONOMIC OPPORTUNITY ACT PLAN

One part of the economic opportunity act concerns the organization, administration, and supervision of adult basic education programs for those adults whose lack of such education handicaps them in finding and keeping productive employment and in meeting their adult responsibilities.

Grants to the states may be used to assist local school systems in developing pilot projects and in meeting the cost of programs of instruction for adults. Pursuant to federal regulations, a plan of cooperation has been formalized relating to the above between the state Departments of Education and Health.

A statement regarding the plan cites the cooperative relationship between the two departments with respect to the joint school health program for health services of children of school age and to older children and young adults in need of vocational rehabilitation and affirms that existing health services, facilities, and programs will be available to the people participating in the adult education program. Hope is expressed that it will be possible to develop a program of health screening designed to systematically provide early medical screening of these disadvantaged people to achieve maximum preventive medical action.

FLUORESCENT TECHNIQUE IN RABIES DETECTION

The use of the fluorescent antibody technique, a comparatively new diagnostic tool, was inaugurated in the routine diagnosis of rabies early this year in the Bureau of Laboratories. One of the many advantages of the fluorescent technique is the detection of virus in tissues of rabid animals, some of which fail to form the characteristic Negri bodies, formerly the sole means of rapid diagnosis. This is particularly important in such animals as bats, which may carry the infective virus in the salivary glands when it cannot be detected in the brain.

The value of the routine application of this fluorescent antibody technique was demonstrated in a recent run of rabies examinations by enabling

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prompt and accurate diagnoses in two cases of animal rabies (one in a squirrel in Anne Arundel County and one in a bat in Baltimore City).

RABIES CONTROL MEASURES

In addition to the animal trapping program instituted in the Glen Burnie area recently, a cooperative program of rabies vaccination clinics was jointly sponsored by the state and local health departments and the Maryland State Veterinary Medical Association in Anne Arundel and Baltimore counties. Four rabies vaccination clinics for dogs were offered in the affected areas. At these self-financed clinics, owners paid $1 per dog vaccinated. More than 2,000 dogs were vaccinated. Hopefully, rabies clinics can be offered routinely in other areas of the state as a means of control of the disease.

CDEH RENAMED PACKAGED DISASTER HOSPITAL

The Division of Health Mobilization, Public Health Service, Department of Health, Education, and Welfare, has changed the title of the Civil Defense Emergency Hospital. Change is based on the need to convey the concept that these hospitals can be used for critical natural disaster situations where life and health may be in jeopardy and not limited to civil defense emergencies. The release of these hospitals in any disaster will continue to be the responsibility of the Regional Health Director, Public Health Service .

The new name selected for the Civil Defense Emergency Hospital is *Packaged Disaster Hospital (PDH)*.

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STATE OF MARYLAND

DEPARTMENT OF MENTAL HYGIENE

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

The National Scene

In 1963, for the second year in a row, reported expenditures in the United States for the maintenance of state and county operated mental hospitals exceeded one billion dollars. This was a reported increase of 5 per cent, or 51 million dollars, over the previous year's comparable figure. Total maintenance costs have doubled since 1953 and are now almost 40 per cent higher than they were five years ago.

Hospital expenditures have continued to go up, although the average number of patients in these facilities has decreased steadily. Nationally, a decline in the patient population of 5.5 per cent (from 542,000 to 512,000) occurred between 1958 and 1963. As a result, the average cost of caring for one patient for one day has risen substantially. In 1958, the national daily per capita was $4.04. By 1963, this had increased 43.8 per cent to $5.81. Despite this, expenditures continue to lag behind comparable figures from federal psychiatric hospitals.

While these rising cost figures undoubtedly indicate some improvement in treatment services, they are mainly a reflection of the rapidly increasing patient turnover resulting from shortened periods of hospitalization and the release of many long term patients. As indicated in Table 1, both admissions and releases have risen considerably between 1958 and 1963. In fact, this rise has been so large that the average expenditure required to produce one release is now less than it was five years ago.

If present trends continue, average daily costs per patient must be expected to rise materially at the same time that the average total cost of each treatment episode declines. The only alternative to continuing, uninterrupted increases in total psychiatric hospital expenditures is to reduce the number of admissions and to decrease further the average length of hospitalization. This can be accomplished through coordinated programs offering a variety of community and hospital services to the mentally disturbed and the implementation of current and new concepts for the prevention of mental illness.

Table 1

FISCAL YEAR	ADMISSIONS	NET RELEASES	TOTAL EXPENDITURES	EXPENDITURE PER NET RELEASE
1958	209,503	161,972	$ 805,861,786	$4,975.32
1963	285,244	247,228	1,084,713,981	4,387.50

The above newsletter marks the completion of five years of these reports. We are most grateful for the statements of interest and support we have received during this time and invite all comments and suggestions.

Kurt Gorwitz



Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

Old books, as you well know, are books of the world's youth, and new books are fruits of its age.—Oliver Wendell Holmes

WHY DO THE FAME and esteem of the various rare books and their authors continue? Their fame was originally made by their authority and was entirely independent of the acclaim of the majority. They were accepted by a few at first, then it grew upon the majority.

It is by the "passionate few," to quote Arnold, that the renown of genius is kept alive from one generation to another. The qualities in a book which make it a lasting pleasure might be truth, insight, knowledge, wisdom, humor, and beauty. There is a group in our profession to whom books are dearer than to teacher and practitioner, a small silent band, but in reality the leaven of the whole lump. They are often called the bibliomaniacs; they often do not know the difference between *meum* and *tuum*. They love books partly for their contents, partly for the sake of the author. They keep alive the sentiment of historical continuity in the profession. We need more of this in our world where too many judge everything by the tape measure of utility.

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"Not to use a book is more a sin than its misuse."

Louis Krause, MD

RECENT ADDITIONS

Advances in Internal Medicine, Vol. 12, Interscience Publishers, Inc., 1964.

American Medical Association: *Report of the Commission on the Cost of Medical Care.* AMA, 1964.

American Medical Association Council on Legislative Activities: *Legislative Roundup.* AMA, 1961-1964.

American Medical Association Council on Legislative Activities: *Medical Legislative Digest.* AMA, 1961-1964.

American Medical Association Scientific Publications Division: *Style Book and Editorial Manual.* AMA, 1963.

American Neurological Association: Transactions. Springer, 1963.

American Surgical Association: Transactions, Vol. 81, 1963.

Anderson, William A. D.: *Synopsis of Pathology,* 6th ed. Mosby, 1964.

Baylor University: *Corneal Contact Lenses.* Mosby, 1964

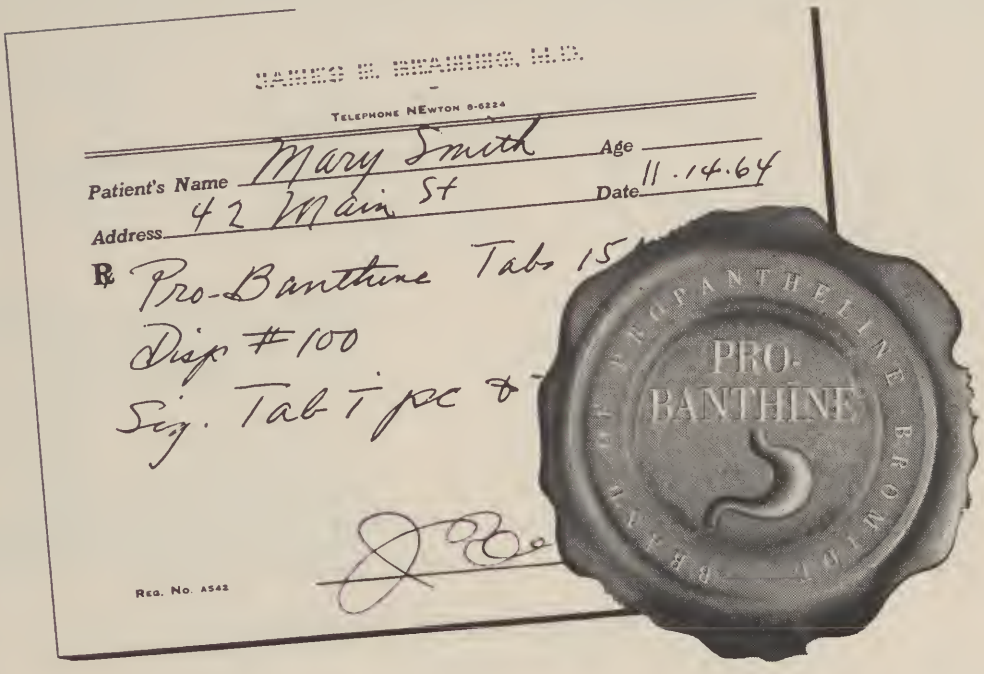
Beard, Gertrude: *Massage: Principles and Techniques.* Saunders, 1964.

Black, Maurice Meyer: *Dynamic Pathology; Structural and Functional Mechanisms of Disease.* Mosby, 1964.

Boies, Lawrence R.: *Fundamentals of Otolaryngology: A Textbook of Ear, Nose, and Throat Diseases.* Saunders, 1964.

Christensen, Halvor H.: *pH and Dissociation: A Learning Program for Students of the Biological and Medical Sciences.* Saunders, 1964.

Duncan, Garfield George: *Diseases of Metabolism: Detailed Methods of Diagnosis and Treatment.* Saunders,



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Henry, Robert S.: *The Armed Forces Institute of Pathology, Its First Century, 1862-1962.* Office of the Surgeon General, Dept of the Army, 1964.

International Conference on the Biology of Cutaneous Cancer. Public Health Service, 1962.

International Congress of Physical Medicine, Third. Proceedings. American Congress of Physical Medicine and Rehabilitation, 1960.

Jenkins, Marion T.: *Anesthesia for Patients With Endocrine Disease.* Davis, 1963.

Montgomery, Desmond A.D.: *Clinical Endocrinology for Surgeons.* Williams & Wilkins, 1963.

Nelson, Waldo Emerson: *Textbook of Pediatrics.* Saunders, 1964.

Saenger, Eugene Lange: *Medical Aspects of Radiation Accidents: A Handbook for Physicians, Health Physicists and Industrial Hygienists.* Atomic Energy Commission, 1963.

Strauss, Lucille: *Scientific and Technical Libraries: Their Organization and Administration.* Interscience, 1964.

U. S. Army Medical Service: *General Surgery.* Office of the Surgeon General, Dept of the Army, 1955.

U. S. National Cancer Institute: *Cancer Services and Facilities in the United States.* Public Health Service, 1960.

U. S. National Heart Institute: *A Handbook of Heart Terms,* 1964.

U. S. Public Health Service: *Medical School Facilities: Planning Considerations and Architectural Guide,* 1961.

World Directory of Medical Schools. World Health Organization, 1963.

Year Book of Anesthesia 1964-1965. Year Book Medical Publishers.

Year Book of Cancer 1963-64. Year Book Medical Publishers.

Year Book of Cardiovascular and Renal Diseases 1963-64. Year Book Medical Publishers.

Year Book of Medicine 1964-65. Year Book Medical Publishers.

Year Book of Obstetrics & Gynecology 1964-65. Year Book Medical Publishers.

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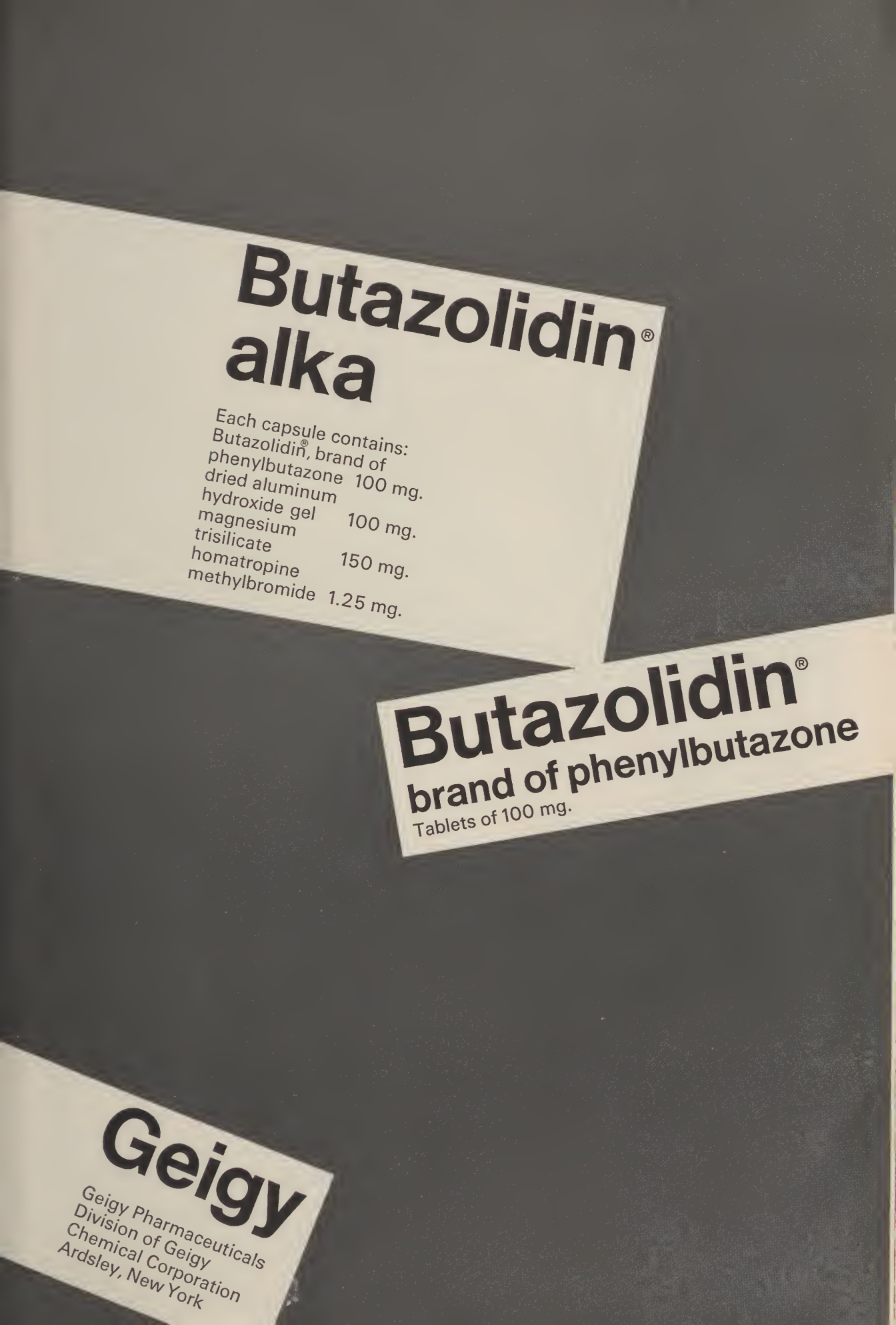
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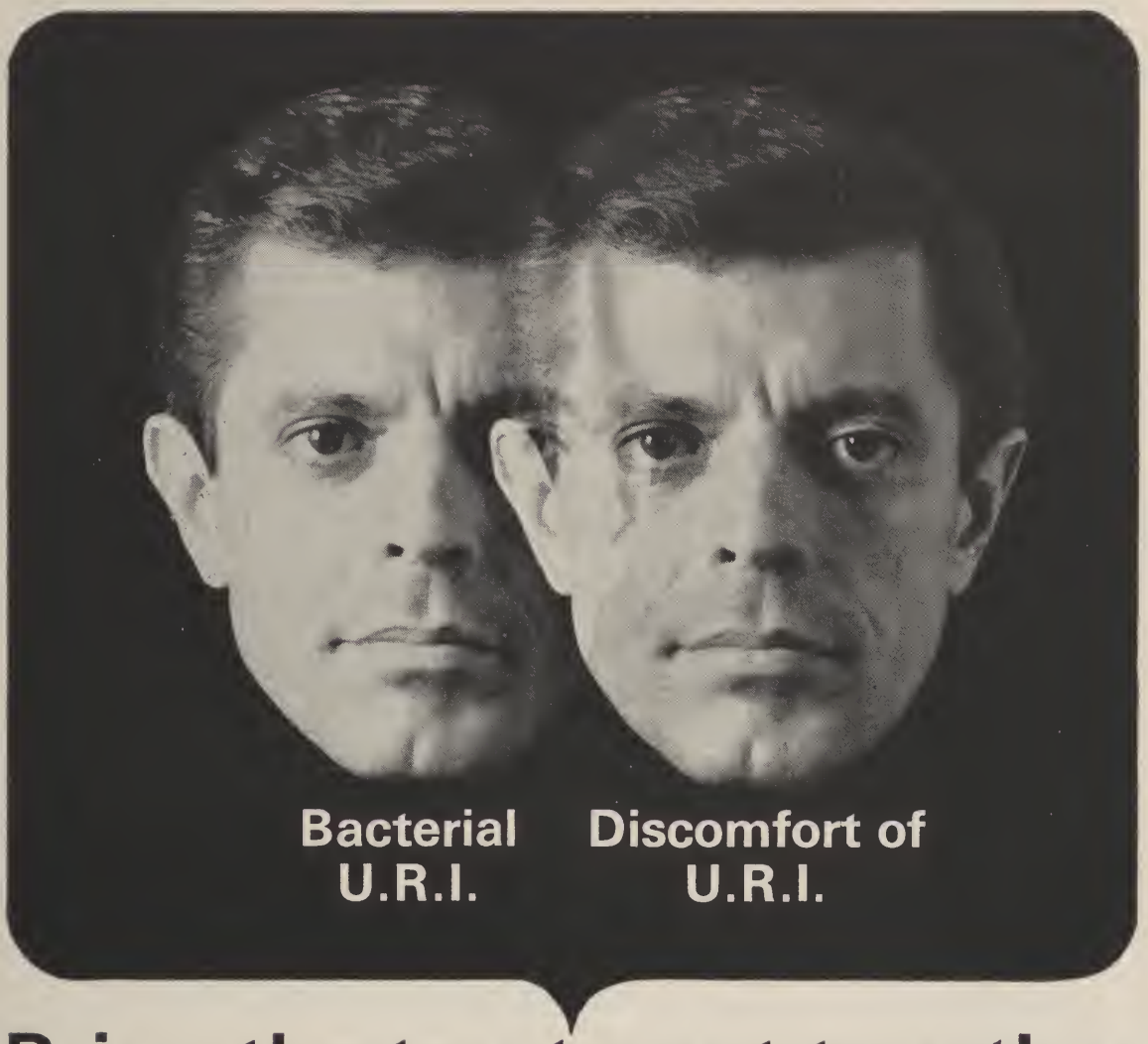
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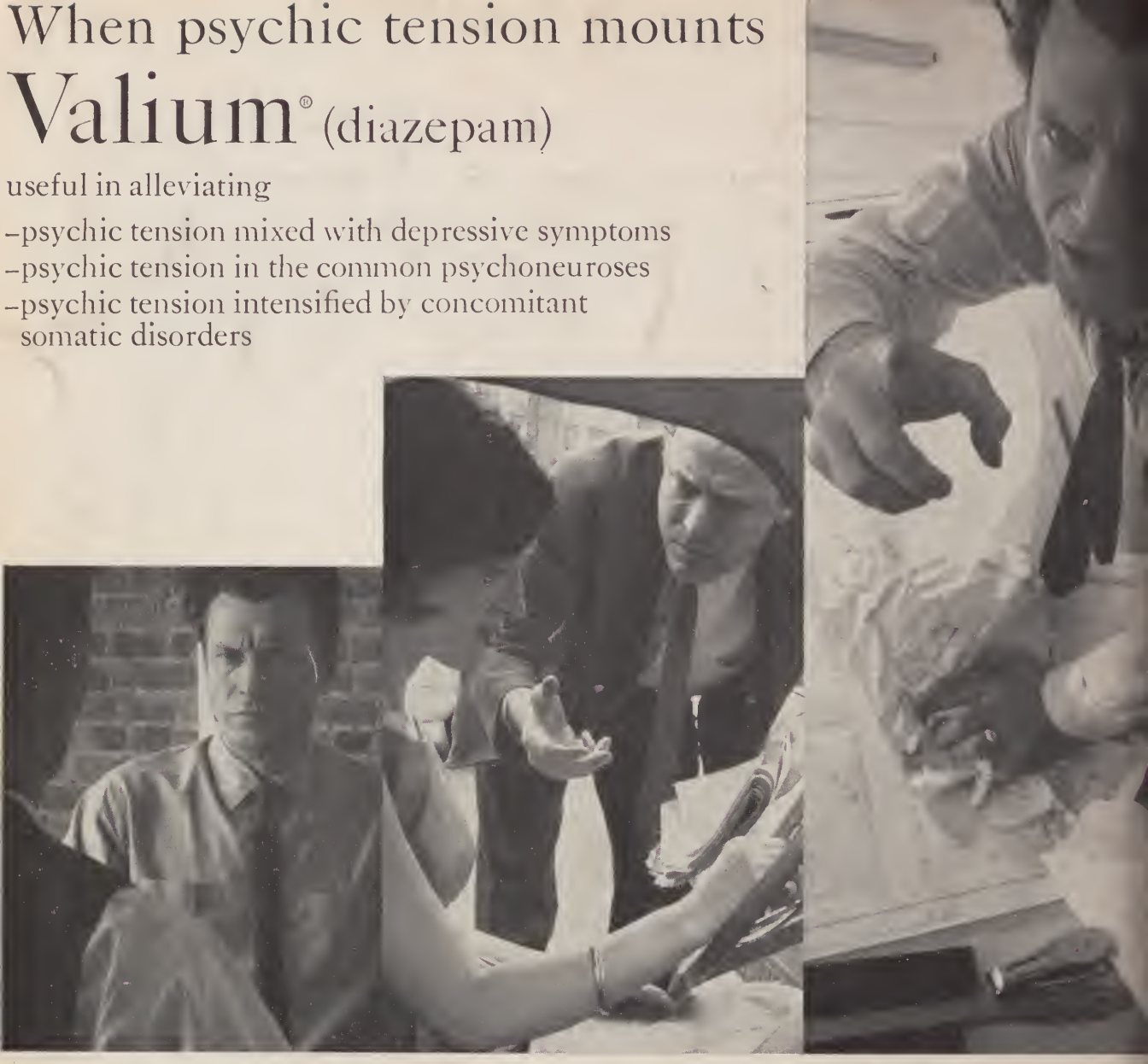
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MEDICINE AND RELIGION

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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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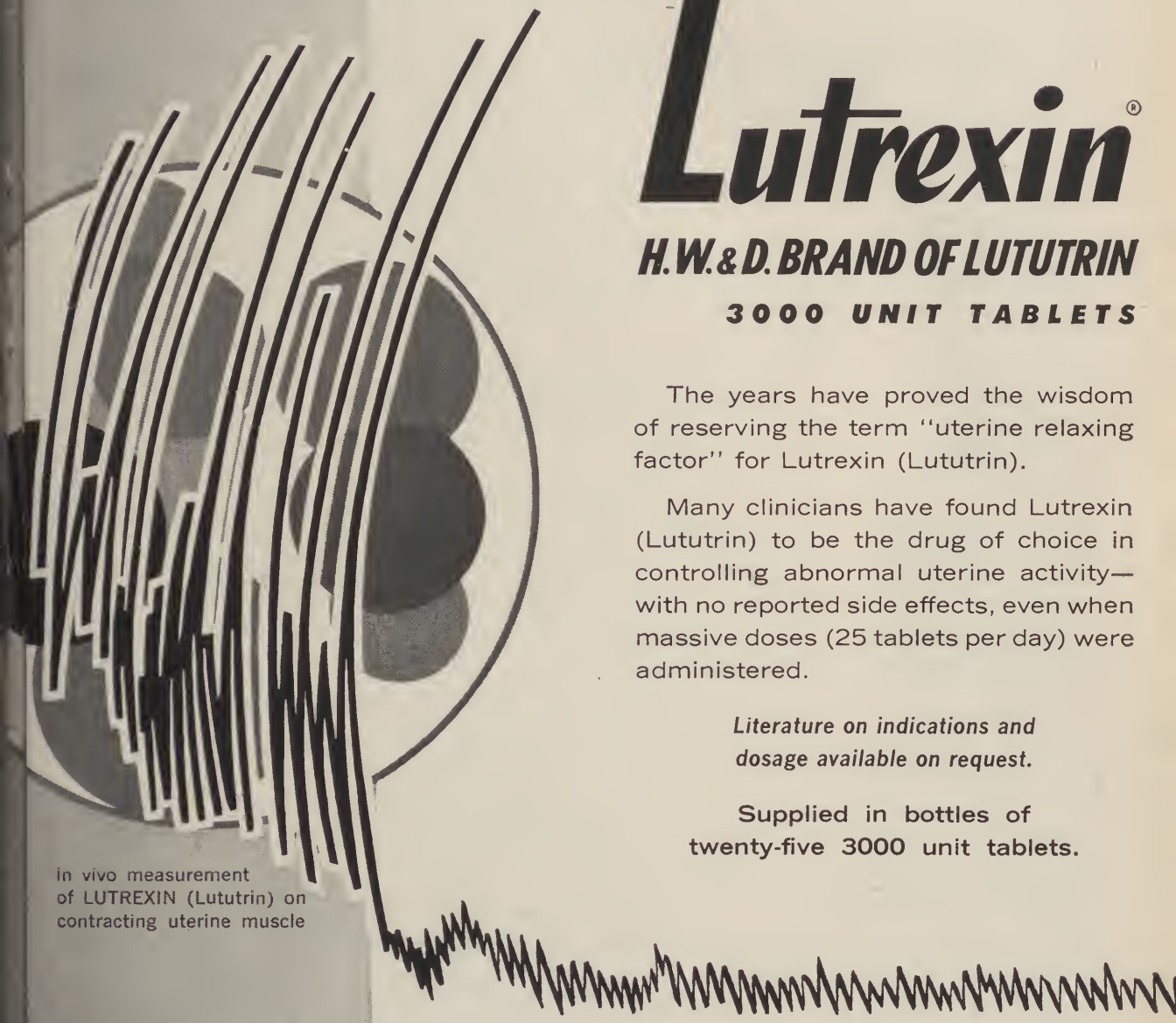
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Doctors take note...

MARK THESE IMPORTANT DATES ON YOUR CALENDAR

April 21-23—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland. See program on page 54-55.

June 20-24—Annual convention, American Medical Association, New York City. See *JAMA* May 10 for complete scientific program and registration forms.

MARYLAND SOCIETY OF INTERNAL MEDICINE

March 29—8:15 PM—1211 Cathedral Street, Baltimore

Joint meeting with BCMS Section on Internal Medicine

"Physiologic Basis for the Treatment of Refractory Shock," Arlie R. Mansberger, Jr., MD, associate professor of surgery, University of Maryland School of Medicine. Discussant: Leonard Scherlis, MD, associate professor of medicine, University of Maryland School of Medicine.

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

March 29-April 10, Chicago

This course, limited to 15 physicians, will be under the direction of Paul H. Holinger, MD, and will be held at the new Illinois Eye and Ear Infirmary, 1885 W. Taylor St., Chicago. Instruction will be provided by means of animal demonstrations, practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, 1853 W. Polk St., Chicago, Ill. 60612.

CARDIAC SYMPOSIUM

March 31—Marriott Twin Bridges Motor Motel, Virginia

Sponsored by the Heart Association of Northern Virginia. Additional information may be obtained from the Heart Association of Northern Virginia, Inc., 609 N. Edgewood St., Arlington, Va. 22201.

BALTIMORE CITY MEDICAL SOCIETY

April 2—8:30 PM—1211 Cathedral Street, Baltimore

Semiannual business meeting.

AMERICAN SOCIETY FOR THE STUDY OF STERILITY

April 2-4—San Francisco

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AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

April 4-8—San Francisco

Thirteenth annual clinical meeting. Registration open to all physicians. Details from American College of Obstetricians and Gynecologists, 79 West Monroe St., Chicago, Ill. 60603.

SPRING CONGRESS IN OPHTHALMOLOGY

April 5-8—Roanoke, Va.

Sponsored by Gill Memorial Eye, Ear and Throat Hospital. Write to E. G. Gill, MD, 711 South Jefferson Street, Roanoke, Va.

AMERICAN INDUSTRIAL HEALTH CONFERENCE

April 5-8—Miami Beach, Fla.

Co-sponsored by Industrial Medical Association and American Association of Industrial Nurses. Further information available from American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

April 6—7:30 PM—1211 Cathedral Street, Baltimore

Business meeting.

MARYLAND OPHTHALMOLOGICAL SOCIETY

April 8—8 PM—Sheratan Belvedere Hatel, Baltimore

Cocktails 6 PM—Dinner 7 PM

"Pre-schaol Visian Testing," Robert R. Trotter, MD, chairman, Divisian af Ophthalmalogy, West Virginia University School of Medicine.

AMERICAN ACADEMY OF GENERAL PRACTICE

April 12-16—San Francisca

Seventeenth annual scientific assembly, featuring talks an birth cantral, pesticides, and new teaching methads. Thirty-twa speakers and 100 scientific exhibits will facus special attentian an community health problems and the family physician's respansibility taward them. Details available fram The American Academy af General Practice, Valker Blvd. at Braakside, Kansas City, Ma. 64112.

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April 18-21—White Sulphur Springs, W. Va.

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MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

April 22—7:45 AM—Sheratan Belvedere Hatel, Baltimare

Breakfast meeting. See page 56 for details and reservatian farm.

CONGRESS ON ENVIRONMENTAL HEALTH PROBLEMS

April 26-27—Chicaga

Sponsared by AMA Committee on Environmental and Public Health. Theme: "Papulatian, Enviranment, and Health." Write ta Department of Environmental Health, American Medical Assaciation, 535 Narth Dearbarn St., Chicaga, Ill. 60610.

AEROSPACE MEDICAL ASSOCIATION

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BCMS COMMITTEE ON MEDICINE AND RELIGION

April 29—4 PM—1211 Cathedral Street, Baltimare

"The Medicine af the Persan," Paul Tournier, MD, Geneva, Switzerland. Dr. Taurnier, a physician since 1928, is in the active practice af psychatherapy. He is a member af the internatianal meetings cancerned with Christian faith and medical practice held at the Ecumenical Institute in Switzerland. He is warld known far his writings. Same af his baaks are: *The Whale Persan in a Braken Warld, A Dactar's Case Baak in the Light af the Bible,* and *The Medicine af the Persan.* Invite yaur pastor to attend this meeting with yau.

NATIONAL ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES

May 6-8—Holiday Inn-Dawntawn, Baltimare

Theme af second annual canference is "Expansian af Cammunicatian Between Prafessianals and Parents." Amang the speakers are Ruth Baldwin, MD, Raymand L. Clemmens, MD, C. Keith Conners, MD, Jahn Maney, MD, Henry Mark, MD, Lawrence C. Pakula, MD, from Baltimore. Write Maryland Associatian for Brain Injured Children, 320 Maryland Natianal Bank Bldg., Baltimare, Md. 21202.

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Sunday, April 4—2 PM

"Spare Parts far Your Bady," participants ta be announced.

Sunday, April 11—2 PM

"Anesthesia," Donald W. Bensan, MD.

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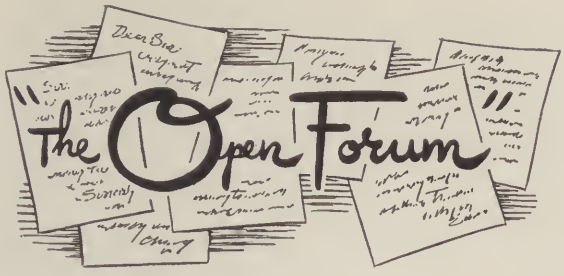
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To The Editor:

Following is the text of my letter to the *Sunpapers,* which was published in part. I would like to bring it to the attention of the *Journal* readers.

"I can't get a doctor"; this is what I heard at a social gathering recently. If this is so, why is it so?

As the incoming President of the Baltimore City Medical Society (1-1-65), one of the important goals of my administration will be to bring about a better understanding between patient and doctor. Many patients would like to think of their physician as the old-time doctor, a man who had plenty of time for his patients and who was considered a member of the family. He was intimately involved with the family and he was the strong arm upon whom its members relied. One of his most potent therapeutic tools was "tender loving care," for he was basically a warmhearted kindly individual.

The doctor of today is sometimes criticized for lacking this important emotion and it is regrettable that some physicians give this impression. However, the modern physician lives and practices in a world of stress in which changes of all types are rapid so that he not only reflects this world in which he is trying to function, but he also reflects his patients' demands and emotions. At the same time he must keep abreast of remarkable new therapeutic measures which were not available in the old days. This requires time and study in order for the physician to administer them intelligently and for him to be fully aware of their side effects and their contraindications. In other words, he has a multifaceted problem which must be understood by the patient just as he, the doctor, must understand that his patient is also a product of a rapidly changing world, with its atom concept, its jet-age propulsion, its population explosion and its increased automation. If only there could be a more wholesome respect, faith and understanding between doctor and patient, much more could be accomplished .

To this end the Baltimore City Medical Society is expanding its committees to include what might be termed "zonal representatives" so that problems regarding medical aid to the aged, community health matters, human renewal, day-care and emergency services, availability of doctors, can all be responsibly referred, hoping that there is enough personnel available to approximate an increasing degree of personal care in these areas of private and community needs. In order to accomplish this, patients must understand their problems to some degree. They must carefully consider their requests and demands to determine whether they are reasonable and they must be willing to discuss freely with their physician exactly what their mutual problems are.

The Baltimore City Medical Society is also arranging for liaison committees with hospitals and with general practitioners so that here again, a better understanding can be generated and thus reflect improved medical care in every area and to every person.

Much has been written and said about the physician which tends to create an erroneous public image. It is unrealistic to think of the physician of many years ago as representing what might be called a "father image," and to have too different a concept of the physician in the setting of today. The latter is working in an entirely different atmosphere. Basically, however, he has the emotional assets and motivations of a well-trained and adjusted doctor. It is inconsistent that the majority of patients think of their own physician as "the best doctor in the world" and yet conceive of the medical profession as a whole as less than this.

In a tense world where people are frightened, it is often in the doctor's domain where help is needed both psychologically and physiologically, not to mention the obvious needs in the pathological or organic or disease area. It is this service which the doctor wishes to be responsible for and to render. If it would appear that such services are not immediately available, this may be due to a misunderstanding as to methods of obtaining them in today's world. The fact remains that it is the operating room, the hospital in general, the doctor on call at all hours in and out of the hospital, which are accepted as the realities in today's world. No matter where people are assembled, in

stadia, theaters, or other areas, it is the doctor who is being paged more often than anyone else. It is the doctor who can be seen at all hours here and there in suburbia and in inner city. It is the doctor's telephone which is always unpredictable, and it is the doctor who accepts this as both his heritage and his professional responsibility. It should be understood that long hours dedicated to the fulfillment of these responsibilities tend to exhaust the doctor physically and mentally and this should in part be understood and some allowance made.

As physicians we intend to do our part. We hope the public will not only understand this but will be aware of and sympathetic to our problems, and by taking this view assist us in our efforts in their behalf. The public and the physician together have a vital stake in medical and health progress. Also, we covet the support of the press as an important medium of information to help the physician communicate this purpose, this good will, this objective, this desire, to every strata of society. We shall welcome this cooperation and we trust that Baltimore will set an unexcelled pattern for the State and Nation in this significant area of human relationships—patient-physician.

Samuel Morrison, MD, President
Baltimore City Medical Society
January 18, 1965

To The Editor:

Your editorial in the *Journal* of December 1964, page 15, is very apropos:—

"Why, you might ask, do we need to entice readers? One reason is that our *Journal's* purpose —communication with Maryland physicians—is achieved only when it is read. Of the mass of medical literature which crosses your desk, only the *Maryland State Medical Journal* informs you of the activities of your state medical society; only the *Maryland State Medical Journal* contains news of your Maryland colleagues; only the *Maryland State Medical Journal* publishes information particularly intended for the Maryland physician."

As the result of the meeting of the Baltimore City Medical Society Board of Directors, with the City Component Reporter, on account of its statewide membership interest and importance, and, in order that the members may contact their Delegates in time, he advised me to address this to you, to channel it to the State Society Reporter, whose identity I do not have but is known to you.

Censorship powers over membership affairs are not written into or implied in the office of the Editors. Their duties encompass editing of the scientific work and the mechanical functioning of the *Journal;* and as you state, to circulate the non-scientific news and facts to the members. Otherwise, if matters so vital and important to the general membership as voting have to be circulated and directed to them outside the *Journal,* the question might arise as to the need for a State Journal. Why just another Medical Journal and to what purposes, or for whose benefits?

In reference to the circular mailed to all voting members of the Medical and Chirurgical Faculty of Maryland (the State Society), who agree with the need for amending our Voting By-Laws, to date I have received 522 returns in favor of the change. 211 votes are from the city and 311, about 3 to 2 ratio from the other components of our State Society.

May I bring your attention to the fact that in the past three years, the greatest election returns both pro and con of the Baltimore City Medical Society was 179 out of the total number of voting members in 1963. Voting in 1962 both pro and con tallied 93, and in 1964 when the entire day was given to voting, the total pro and con was 115 votes. This would average less than 10% of the voting membership in contrast to the present returns desiring the Voting By-Law changes.

As "only the *Maryland State Medical Journal* publishes information particularly intended for the Maryland physician," the State Reporter may wish to note this matter of importance to the entire membership, in the *Journal* as soon as possible, as an expression of the desire of the members of all the components of the State Society. The By-Laws Committee and the Delegates of the various components can note their wishes and act in sufficient time for the April Session.

M. B. Levin, MD

To The Editor:

I wish to inform you that the "Istituto Nazionale della Previdenza Sociale" (Italian National Institute for Social Security) has made available

to foreign doctors of medicine and surgery, specializing in diseases of the chest, scholarship funds to be used annually at the "Istituto Carlo Forlanini" of Rome and the "Istituto Principe di Piemonte" of Naples. These scholarships afford an opportunity to foreign doctors to study equipments used in sanatoria in Italy and to conduct researches on therapeutic methods practiced in the field of phthisiology.

The scholarships may have different duration and consist of 80 monthly installments for room and board, of which 40 are to be used at the "Istituto Carlo Forlanini" and 32 at the "Istituto Principe di Piemonte."

The awarding of these scholarships is not subject to any condition. However the "Istituto Nazionale della Previdenza Sociale" wishes to know if there are in this country institutions willing to offer similar scholarships to Italian doctors who are interested in the same field of research and study.

The next academic year will begin on November 1, 1965, and will end on June 30 of the succeeding year. Candidates should submit to this consulate general a few weeks before the deadline of July 31, 1965, their petition, their curriculum vitae, letters of presentation, and any other document which may be considered useful.

The candidates to whom the scholarships are awarded will be notified by this consulate general.

I should greatly appreciate it if you would bring the preceding communication to the attention of those individuals and institutions which may be interested in the plan.

G. P. Nuti
Consul General
2128 Locust Street
Philadelphia, Pa. 19103

NEW MOUNT VERNON MEDICAL BUILDING

A new plan for the east end of Mount Vernon Square was announced recently. It involves construction of a five-story building planned and designed for medical offices.

Lloyd F. Bond, president of the H. T. Geisendaffer Realty Company, leasing agents for the proposed Mount Vernon Medical Building, said the structure will be built on the northeast corner of St. Paul and Monument streets.

The structure will contain ample parking for tenants and patients on two levels.

Mr. Bond said the building would cost about $1,500,000 and would contain between 35 and 40 suites.

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*A.M.A. Council on Drugs: J.A.M.A.183:469 (Feb. 9) 1963.

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EXECUTIVE SECRETARY'S NEWSLETTER

March, 1965

EWS NOTES

Emma L. Barbarich, M.D., St. Mary's County, has received Board certification in Pediatrics.

Willard A. Burns, M.D., Bethesda; Howard A. Reidbord, M.D., Kensington; and Norbert J. Matzinger, M.D., of Baltimore, have all been certified as Diplomates of the American Board of Pathology.

Frank U. Lee, M.D., of Baltimore, has been certified as a Fellow in the American College of Anesthesiology.

ICENSE REVOCATION

The license of Bennett A. Robin, M.D., has been revoked by the Board of Medical Examiners of Maryland.

EDICOLEGAL CODE REPRINTS

Reprints of the adopted Medicolegal Code of Cooperation are available through the Faculty office.

The Code has been adopted by the Faculty's House of Delegates, as well as the Baltimore City Bar Association and the Maryland Bar Association.

NTERNISTS TO MEET

The first joint meeting for 1965 of the Maryland Society of Internal Medicine and the Baltimore City Medical Society Section on Internal Medicine is scheduled for Monday, March 29, at 8:15 p.m., in the Faculty Building.

The speaker will be Arlie R. Mansberger, Jr., M.D., Associate Professor of Surgery at the University of Maryland Medical School. He will talk on Physiologic Basis for the Treatment of Refractory Shock.

MMPAC BREAKFAST MEETING

The Maryland Medical Political Action Committee has scheduled a breakfast meeting on Thursday, April 22, 1965, at 7:45 a.m., at the Sheraton-Belvedere Hotel. Reservations may be made through the MMPAC office or through the reservation blank found in this issue of the JOURNAL.

PHYSICAL FITNESS CLINIC

The President's Council on Physical Fitness is sponsoring a regional fitness clinic for eight Mid-Atlantic states in Harrisburg, Pa., on March 26 and 27, 1965.

The Faculty is acting as a cooperating agency for this program and all interested Faculty members are urged to attend the session.

Further details are available through the Faculty office.

PHYSICIANS' SHARE OF MEDICAL DOLLAR

The physicians' share of the medical dollar has dropped from 30¢ to 29¢ during the ten-year period, 1953-63.

Other portions of the medical care dollar have changed as follows:

	1953	1963
Dentists	11¢	10¢
Medicines & Appliances	25¢	24¢
Hospital Services	29¢	32¢
All other medical care	5¢	5¢

(Source - U. S. Dept. of Health, Education & Welfare).

REFERENCE COMMITTEE MEETING

The Reference Committee meeting is scheduled for

THURSDAY, MARCH 25, at 8:00 p.m.

at the Faculty Building.

WE ALL HAVE A CONGRESSMAN AT-LARGE

Many of us forget to write to Congressman Carlton Sickles, who is a Congressman At-Large. This means that you should make contact with his office, as well as your own Congressman, AND SENATORS, when contacting them promoting the passage of ELDERCARE. Just a reminder!

John Sargent

Executive Secretary

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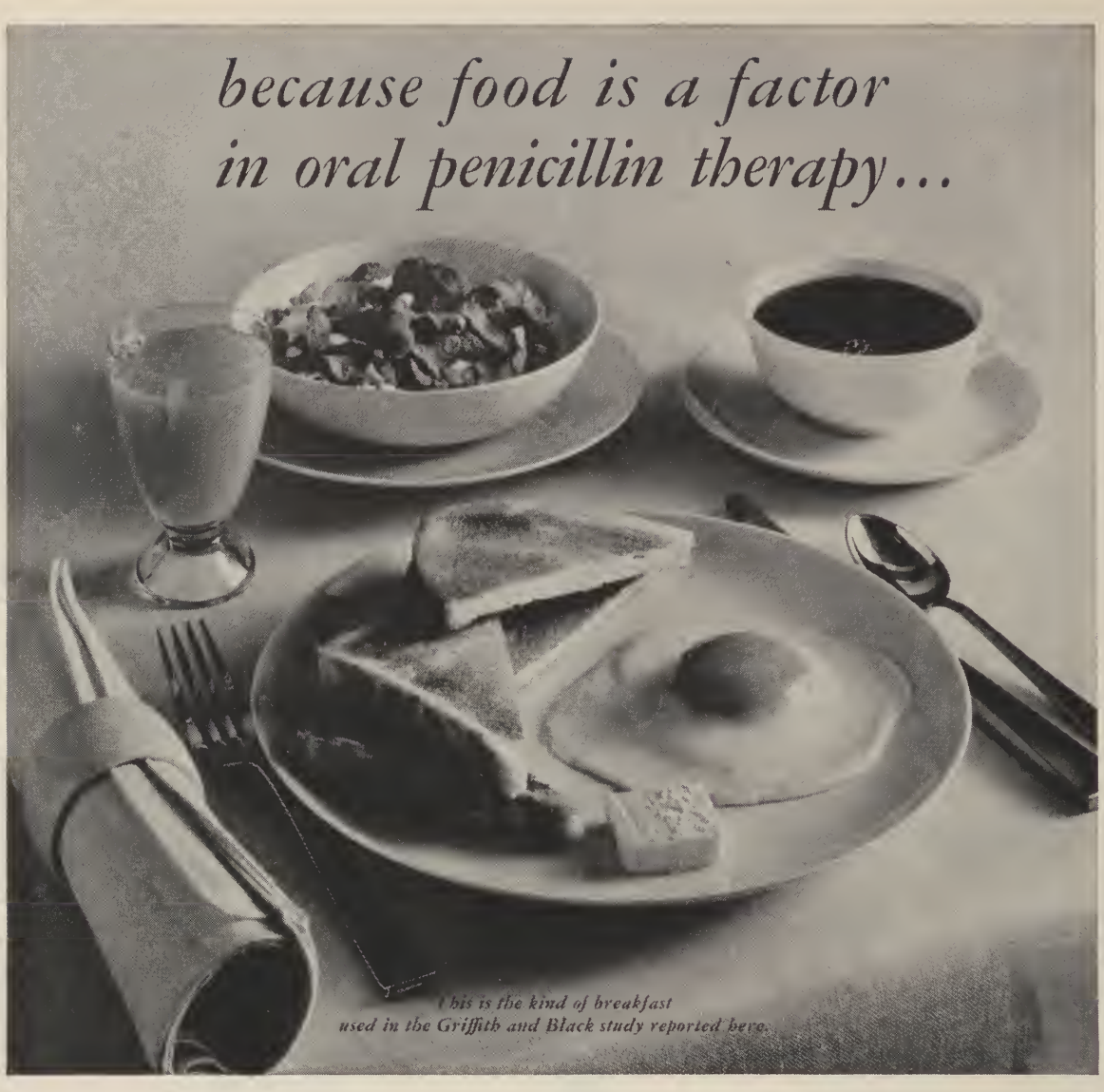
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1. Griffith, R.S., and Black, H.R.: Current Ther. Res., *6*: 253, 1964.

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Maryland State Medical Journal
Vol. 14, No. 3
March, 1965

Editorial

Medicine and Religion

JOHN F. SCHAEFER, MD
Chairman, Liaison Committee

"Man does not live by bread alone." Nor is he cured by medicine alone. A man's faith may be as important to his recovery as the treatment he receives. If he is dying, his faith may do more than medicine to ease the final hours or days of his life.

For thousands of years, to varying degrees, religion has had its influence on medicine. In 1961, formally acknowledging the common interest of physicians and clergymen in the physical and emotional well-being of their patients and parishioners, the AMA established its Department of Medicine and Religion. The aim of this department is to create a channel of communication between physicians and clergymen in order to give patients the best possible care and treatment. To better fulfill this purpose, the state medical societies have been encouraged to form medicine and religion committees and to promote meetings between physicians and clergy in local communities to explore and resolve mutual problems.

In Maryland, the Medico-Religious Subcommittee of the Liaison Committee held its first meeting in January, 1964. It adopted the aims formulated by the AMA Department of Medicine and Religion and set up a program of implementation. In May the second meeting was held and included clergymen representing major religious creeds. At this and subsequent meetings, physicians and clergymen expressed their common problems, made known what each expects from the other, and proposed specific objectives.

This issue of the MARYLAND STATE MEDICAL JOURNAL represents one of the first recommendations of the subcommittee. Herein are articles written by both physicians and clergymen. Introducing the theme is an article on "Treatment of the Whole Man" by Louis Krause, MD, who also had the responsibility of gathering and editing the articles on medicine and religion.

The topics "What the Doctor Expects of the Pastor," and "What the Clergyman Expects from the Doctor," are elaborated on by Melvin N. Borden, MD, and Edgar P. Williamson, II, MD, and by the Reverend Harold Popp, respectively.

Three articles consider aspects of medico-religious cooperation in action. First, the pilot program in Wicomico County is described by I. Rivers Hanson, MD. Practical programs in a large and a small hospital are described by Father Walter T. Gouch, CSP, Johns Hopkins Hospital, and the Reverend William D. Nofziger, Washington County General Hospital.

The Reverend Manfred Manrodt, of the Maryland Council of Churches, tells how this group relates to the practice of medicine. Finally, a review of the various religious rites has been prepared with the cooperation of religious leaders in many denominations.

To further implement the aims of this subcommittee, a film entitled "The One Who Heals" has been purchased for use throughout the state by component medical societies, hospital staffs, religious groups, and other interested groups. In cooperation with this subcommittee, the Committee on Emotional Health is preparing a list for clergymen to use in making psychiatric referrals.

Whether through a formal committee on medicine and religion or through individual efforts, liaison between the two professions is being accomplished in Baltimore City and Maryland's counties.



Doctor's Day—March 30, 1965

Doctor's Day is a special day set aside each year to honor the members of the medical profession, both living and dead, who have devoted their lives to the art of healing.

The idea of Doctor's Day originated in Georgia in 1933 and was adopted by the Woman's Auxiliary to the American Medical Association in 1934. In 1949 the red carnation was chosen as the symbol of Doctor's Day.

March 30 is the official date, commemorating one of the greatest discoveries for the alleviation of pain and suffering. On March 30, 1842, Dr. Crawford W. Long first used ether anesthesia in surgery.

In honor of Doctor's Day, the Woman's Auxiliary to the Baltimore City Medical Society is donating a sum of money to the American Medical Association Education and Research Foundation, to be divided equally between The Johns Hopkins and the University of Maryland Schools of Medicine.

MRS. FERDINAND E. KADAN, *President*
Woman's Auxiliary to the Baltimore City Medical Society

MRS. JOHN H. HIRSCHFELD, *Chairman*
Doctor's Day

Treatment of the WHOLE MAN

LOUIS KRAUSE, MD

In the practice of medicine the doctor must first of all accept the patient as he is without question of status, creed, or color.

While listening to the patient's complaint and history, the physician should have several questions uppermost in his mind: What body system is responsible for the patient's complaint? Is the illness reversible? Then the doctor considers the cause of the illness.

One always hopes that the disease is reversible, usually indicating no structural or architectural changes. This places it in the realm of altered physiology, the domain essentially of psychosomatic medicine, this being the stage before organic change takes place. It is doubtful that any thinking human being is ever without a psychosomatic componet in addition to his organic disease. The degree to which he may be influenced by altered physiology probably bears a direct relationship to his normal concern or responsibility and to his acceptance or rejection of some religious teaching—his orthodoxy. If he bears a great deal of moral responsibility as we understand it in the ethics of our civilization, one can readily comprehend the reaction that may occur when some ethical code is strained. This may be manifested as a fluctuating hypertension, duodenal ulcer, or functional disturbance of any system.

After the doctor has completed the history and performed a thorough physical examination and the indicated laboratory studies, if he cannot make a diagnosis of any organic disease he then thinks of a psychogenic phenomenon. Let it be understood that we must never pass judgment on the patient. The same holds true for the clergyman. We may only place the findings before the patient.

Too often the physician does not know the

There probably is a bit of the psychosomatic in every organic disease, and the patient is best helped by due consideration for both his body and his spirit.

Medicine & Religion /

spiritual and emotional background of the patient. Any orthodox Hebrew or fundamentalist Christian may react adversely and violently to certain ethical infractions compared to the indifferent approach to the same situation by the liberal minded. This is one way in which the believer may suffer from his sin, the meaning of the word sin being to aim or hit below the mark or bullseye. One needs to experience this in practice to know how true it is and how disturbing this phenomenon can be. "A merry heart doeth good like a medicine," said the proverbialist. Likewise in the economic and business world, the frustrations that occur only too often produce altered physiology with all that may ensue. Here again the proverb, "Hope deferred maketh the heart sick, but when the disease cometh it is a tree of life," is true.

One's mores can profoundly influence one's health. In primitive society the doctor's pronouncements are often very effective for good or bad because they are believed by the patient. It reminds one of the quip, "Its not so much what the patient eats but what is eating the patient."

This brings us to the role of the clergyman or spiritual advisor in relation to the patient. In this issue will be found some of the credos practiced and taught to our patients. You will notice that they vary a great deal. There is one God, to be sure, but the approach ranges from the formal to completely informal with acceptance up to the suppliant. Food taboos may vary according to the source of the food and the days on which it may or may not be eaten. Unless the doctor is aware of these many variations, it will be to his and the patient's advantage for him to consult with the spiritual advisor. The pastor will welcome such consultation. In this way we care for the whole man, his body and his spirit.

The practice of medicine is completing a circle begun in primitive times, when the priest and medicine man were one. Later a dichotomy took place between the two. Now physicians and clergy are meeting together for the good of the patient.

Some give and take is necessary between doctor and pastor, for the clergy have no training in medicine. Although some have been exposed to psychology in college or attended a psychiatric seminar, this usually is the case of a little knowledge being a dangerous thing. It is about as pertinent to medicine as astrology is to astronomy. What is needed is daily observation in a ward or a month's tour on night duty with an orderly. Then will he see his patient in distress and pain. This can be a bracing and wholesome experience. In any event, the clergymen are most willing to help and often can aid the doctor a great deal.

Efforts should be increased to bring about a less formal relationship between clergy and doctor; to share our problems is to lessen the burden. The work of the physician and the clergyman will always follow different paths, each often complementing the other. The doctor follows the scientific apostle, Thomas', attitude toward the patient's problem; he was always interested in the questions: How? What is happening? Can he prove his thesis? The clergyman follows the approach by faith, asking *why* rather than *how*. Why must there be sorrow, pain, and death? He is more interested in how the patient "behaves," whether he is "good" or "bad," and is too often concerned for a system of faith and form of worship. In some areas of experience, faith can be more powerful than logic. This can become contagious and become a source of strength and joy to the patient.

The doctor may have the intellectual concept of God, and the pastor and patient may have the emotional faithlike concept. Both concepts can be satisfying and helpful to the patient, to whom we are chiefly dedicated as a fellow human being in suffering. It is then that we stand on our Judeo-Christian ethics.

11 East Chase Street
Baltimore, Md. 21202

WHAT THE CLERGYMAN EXPECTS FROM THE DOCTOR

HAROLD POPP
Pastor, St. Luke Evangelical Lutheran Church

AMONG PRIMITIVE PEOPLES one man occupied the position held in modern communities by two professions, medicine and clergy. The medicine man was both priest and physician. In the long years of growth and development, they began to draw apart. Early religious views held disease to be attributed to unfriendly demons or to the just punishment of an angry God; so developing medicine, in order to make any *practical* headway against such pronouncements, turned to a wholly objective study of the cause of disease and its removal.

Both medical science and theology have outgrown the idea of a man's being divisible into separate compartments (body, soul, mind, etc.) with each segment functioning independently of the others. They are moving toward a concept of the total man, in which there are no clear divisions, and the working of each part affects every other part. It is on this ground that

WHAT THE DOCTOR EXPECTS OF THE PASTOR

MELVIN N. BORDEN, MD
and
EDGAR P. WILLIAMSON, II, MD

IN THE PURSUIT OF THEIR WORK, it is highly desirable that both physician and clergyman always be mindful that patients are people and that the administration of professional obligations should be directed to the "whole" person. We are singularly advantaged in that the close application of our training can bring great personal reward. Doctor and pastor can achieve maximum results through genuine team effort, results that cannot otherwise be obtained. Happily, medical practice today is increasingly aware of the necessity of cooperative application of medical-religious ministration.

We have always regarded the clergy as being in somewhat the same position as the physician in the utilization of time, considering that both are, theoretically, always available to the public. Indeed, the pastor may feel an even greater demand of his time. Can you remember hearing anyone ask, "What are the pastor's office hours?"

It is our experience that people today are more than ever consulting their pastor with personal

What the Clergyman Expects from the Doctor

physicians and clergymen can meet; they are each working for the health of the total man. Both see in a patient the body and soul. One is called to bring healing to the body and mind, the other to bring healing to the soul; yet the work of each affects the other.

While I am well aware that from the physician's viewpoint there are many sore spots in our relationship caused by the clergyman's lack of understanding in many areas, the reverse is also true, and it is only by a dialogue that we may cease working at cross purposes and proceed to the ministry of health. Following are a few general points the clergyman would like to make, with some specific examples given for explanation.

Recognition of the pastor as "Seelsorger" (one who takes care of the soul).—Whatever the state of belief or unbelief of the physician, he should recognize that if his patient does have faith, the state of his soul's health will affect the ability of his body to recover. Therefore the presence of the pastor is not as a meddler or interloper but as a Seelsorger, and in the pursuance of the soul's care doctors must allow us as much zeal as they show in their care of the body.

Respect for the faith of the patient.—Many doctors look upon communion or prayer before an operation or visits by the clergyman as an inconvenience or as something upsetting to the patient. Yet these very rites are the means of strength and peace for the spirit so that all the body's energy may be directed toward physical healing.

Honesty.—A doctor may use a clergyman to persuade a patient or his family to consent to an operation or hospitalization without fully explaining alternatives or consequences. It is only through mutual honesty that doctors and clergymen can present a united front in the attack on illness instead of pulling the patient in different directions.

What the Doctor Expects of the Pastor

problems. It follows that the alert clergyman must often find himself wondering whether a given person is in need of medical or religious help. It is therefore natural that the clergyman may then turn to the physician. Every doctor should welcome this sort of query. We believe that this contact can be effected with or without the individual's knowledge, because identity need not be revealed. Some pastors have found it helpful to select a physician or two within their congregation to call on regularly for this sort of "off the record" consultation. If physician referral is deemed necessary, the pastor should recommend that the person in question see a doctor, and the selection should be left to the patient unless he specifically requests otherwise. Should any doubt remain about the necessity for medical help, it is probably best to refer the patient directly to his physician for advice.

Naturally, most patients will go to the doctor first, and most of these require no further help. However, those needing pastoral guidance will ask for it or the doctor may suggest it. Both pastor and doctor should remember the quick advantage of sharing the burden and the reward of securing really superior help for a given patient. A word is necessary here regarding those who require medical help but who have financial embarrassment. It is expected that any inquiry soliciting help for such a patient get sympathetic and prompt attention. The doctor may be able to save much valuable time in dispatching such problems.

It is our experience that a large gray area exists where clergy, with good intention, will assume the obligation of counseling a questionably ill person. We refer specifically to the emotionally sick; and here it is especially desirable that the doctor be contacted, since well-intended advice can be harmful and can sometimes even accelerate the disruption of the sensorium. Briefly, it is best to secure medical advice where any doubt lingers. Many psychiatric patients seek spiritual or legal help, or they consult friends or teachers, lacking the insight to guide themselves to the medical help they may sorely need. The recognition and chan-

Information on prognosis.—Most clergymen have little knowledge of the intricacies of the workings of the body, and the technical terminology of a diagnosis is usually not very enlightening. The pastor would, however, greatly appreciate knowing if a member of his congregation faces the probability of a series of painful operations, adjustment to a physical handicap, permanent invalidism, or imminent death. Any of these calls for reserves of strength, courage, and faith, and both doctor and clergyman should work together for the benefit of the patient. If the clergyman has no knowledge of a serious illness, either because of the patient's fear of admitting or discussing it or because the clergyman cannot discern from the terminology its real effect, he loses valuable preparation time. Few patients would object if you would offer to call their clergyman or suggest they do so when you must give a frightening prognosis.

A doctor must often feel frustrated when he must tender such news to his patient in the few minutes between other appointments. Obviously he feels the need to do all he can to aid the emotional and physical needs of the patient, but he simply cannot take the afternoon off from his other appointments to properly support, prepare, and guide this patient. A clergyman's schedule is flexible enough to do just this, including follow up counseling and home visits.

Clarification of medical terms.—Doctors would probably be surprised at how often a pastor is asked just what a particular disease entails. The doctor has probably fully explained it to his patient, but the patient may not have been able to take it all in or not have understood the terms. Many people are so awed by their doctor, they are afraid to ask questions of him; a few minutes of explanation passed on to the pastor will enable him to calm needless fear.

I am aware that valid objections may be raised to certain of these points. A clergyman must possess special training, experience, and dedication as well as simply good intentions before he can attempt to minister to the sick.

As both physicians and clergymen are engaged in fulfilling the call to serve the total man, they should take every opportunity to communicate in order to better understand and respect one another.

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neling of such a problem is of inestimable value to all concerned.

To us the consideration of a professional confidence is of special importance. The physician expects the clergyman to respect this tradition, and he regards this as an entirely reciprocal arrangement.

Another area of help to doctors is that of indoctrination in religious practices peculiar to the various sects. A doctor will be most appreciative of such reminders; the alert physician will seek such advice, for it is here he depends almost wholly upon the clergy. Younger physicians will especially need this sort of training.

At home, the need for pastoral guidance depends upon circumstances. In the case of an acute illness, the need will probably depend upon whether or not the physician thinks that the illness has changed so suddenly in character that death may be imminent. This is to be considered an emergency, and pastoral help is urgently required.

In the case of the aged person who is confined to the home or to the bed because of physical incapacity, routine pastoral attention is necessary for most patients. These unfortunate people look forward to any change in routine, and the visit of the pastor is an exciting and memorable occasion, because it offers them both spiritual assistance and the chance to discuss personal problems. The physician who will take the time just to listen to the older person does him a great service. The minister certainly does the same, and even more so, because of the spiritual comfort that he can bestow.

In the hospital, the pastor can reassure the apprehensive and bewildered patient. The emotion aroused on entering a hospital as a patient, be it for surgery or for medical treatment, is one of charged apprehension of what may be discovered or anticipation of pain. The physician tries briefly to prepare the patient for what is to come, but his words may not be as reassuring as he thinks, or the patient simply may not understand his technical language. The understanding clergyman can offer comfort and soothe these fears, both by his manner and by his message.

Often during a prolonged illness or in the recovery period after surgery, a patient will become

Medicine & Religion /

What the Clergyman Expects from the Doctor

Both have basically a similar motivation, a deep desire to help fellow man. This might sound idealistic, yet an honest and sincere approach to either profession is a recognition of the importance of the other; and both call to serve the "total man" the unity of the individual. As we look into the future we realize something early man recognized: that both professions are required to heal him fully.

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What the Doctor Expects of the Clergyman

severely depressed. This can occur while he is in the hospital or after he goes home to convalesce. The pastor can do much to bolster the efforts of the physician in promoting the mental and physical well being of the depressed patient.

When a patient's illness is hopeless or terminal, the pastor can help the family to understand and accept a concept that is difficult for most of us to comprehend, that this is God's will and what God has given He is now preparing to take back to Himself. The physician often is not able to offer the necessary comfort at this time, no matter how sympathetic and how understanding he may be.

In the nursing or rest home one finds two types of patients: The one may be of any age who is confined because he is physically helpless, though mentally alert. The regular visitations of his pastor are a blessing to this person. The other type may be young or middle-aged, but usually is in the seventh, eighth, or even ninth decade. He is generally confused but will often respond to the gentle manner and kind voice of the minister, even though, like a small child, he does not comprehend the import of the message.

No nursing home can begin to provide the warmth of an individual home, even though the nursing staff is dedicated, efficient, and keenly interested in the welfare of each patient. The hours drag slowly even under the best of physical surroundings. The organized ministerial groups could do a great service by scheduling regular and routine visits to all nursing and rest homes in their areas.

The average physician, in the course of his daily contacts, often becomes aware of sociological problems which can affect his patients, even when well. The areas which we shall outline in general terms are the broad fields which we think offer a means of cooperation between the physician and the religious leader. So often in a community there are numerous widows and some widowers who live alone; some have adjusted readily to the new mode of living, while others never learn to accept the changed conditions. More often, such older people live with their married children because there is no alternative, due to invalidism or to financial difficulties. This can cause friction. A physician coming into one or another of these homes or on seeing these people in his office can now learn the true state of affairs, if he will listen carefully to the patient. He may personally request the able assistance of the pastor, or he may suggest that the patient seek the aid of the pastor in resolving the difficulties caused by the changed circumstances of living. Working together we can accomplish a great deal in helping these maladjusted and unhappy people.

Martial problems are often the basis for numerous complaints that bring the husband or the wife or both to the physician. Sometimes the doctor can help solve these problems without further assistance; however, there are some areas in the field of marriage which do not raise medical problems, and here the wise physician will advise the patients to seek other help. The minister can often offer invaluable assistance to the marital partners if he believes that he is competent in this area.

The teenage group is another field in which the interested physician and pastor as a team can offer help successfully if both know how to approach the situation with intelligent delicacy. Occasionally, a problem arises when the unmarried teenage girl becomes pregnant. Here the pastor can work successfully with the physician in solving the numerous problems arising from this unhappy situation. The minister must be as objective as the physician in his approach to the problem.

Juvenile delinquency covers a wide range of a social behavior. The interested pastor can cooperate with the physician and the parents in attempting to solve the problems of the disturbed teenager. Often the parents themselves are to blame for the conditions which produce delinquency. Here the church can probably bring to bear more influence than the medical profession. Often various social services must be consulted in working out family problems, and the pastor who is alert to these situations among his congregants can do much to aid in bringing about a favorable solution.

Regrettably, time and space limitations do not permit the complete development and exploitation of the ideas we have set forth. The central theme should be cooperation with the view to producing better care for the patient. We hope that some measure of this can be stimulated by this short paper.

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MEDICO-RELIGIOUS PROGRAM IN WICOMICO COUNTY

Wicomico County was one of the first in the nation to initiate a medico-religious program. Its experience should be helpful to other county medical societies contemplating a similar program.

I. RIVERS HANSON, MD
Chairman, Medicine and Religion Committee
Wicomico County Medical Society

As a pilot county for the AMA's Department of Medicine and Religion, Wicomico was one of the first in the nation to conduct programs for joint physician-clergy audiences. Its program was initiated about two and a half years ago. Some changes in philosophy at the national level have followed recent re-evaluations of the program, but much of the experience of Wicomico County would seem pertinent to a society starting such a program at this time.

A well-known featured speaker is probably the greatest assurance of interest and good attendance at the first meeting of the combined group. Once the program material and speaker are selected, invitations should be sent to all physicians in the society, all guest physicians from the area, and all clergymen in the area, regardless of denomination. After the first meeting, the invitation list for future meetings can be reduced. The ministerial associations generally are of little help in making selective invitation lists; one of the best sources of names of clergymen is the Yellow Pages.

In our experience, interest in the problems of mutual concern was very high among both groups in the beginning. After the first several meetings, clergy attendance remained fairly stable, but physician attendance definitely reflected the quality of the material being presented.

In small-group discussions between the two professions, it was found that care must be taken to prevent deterioration into a personal gripe session. A firm hand by a group leader in keeping the discussion limited to the selected topic is necessary.

Another factor directly affecting physician interest in a continuing program seems to be field of specialty. For example, a surgeon's contact with a specific patient is limited in time and scope of personal relationship, since the patient is referred by the family doctor and returns to him after surgery. For this reason, some surgeons have expressed the feeling that they are less involved in matters of the patient's faith and consequently have little or no lasting interest in this program. This reflects a physician-to-physician relationship existing in Wicomico County which may or may not apply elsewhere.

One of the most successful ventures of this particular committee was the specially planned tours of the local general hospital. Clergymen were invited in small groups to a luncheon at the hospital, after which they were taken to non-patient areas of the hospital. Explanations of the functions of the various departments were directed toward providing the clergy with information which would be of use in their future contacts with patients. Safety precautions, medical records, drug room, and central supply procedures were explained in considerable detail, for example. This background gave the minister material with which he could reassure patients and their families, both as to treatments and cost. Obviously, cooperation of the hospital administration is of prime importance for such a project, but this was easily obtained when the value to the hospital of such a program was emphasized.

Now that the Medicine and Religion program has been launched, annual joint meetings are being planned for this county, most of which will probably feature outstanding speakers and will be presented as regular society meeting programs.

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References: **(1)** Warres, H. L.: *Missouri Med.* 61:27, Jan., 1964. **(2)** Palmer, K. J.: *Week. Urol. Clin. Letter* vol. 6, no. 36, Dec. 24, 1962. **(3)** Carroll, G.: *J. Urol.* 90:476, Oct., 1963. **(4)** Ward-McQuaid, J. F. N. C.; Jichlinski, D., and Macis, R.: *Brit. M. J.* 2:1311, Nov. 23, 1963.



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The large hospital offers a splendid opportunity for the clerical and medical professions to cooperate in the ministry of healing for the total good of the patient and for increased devotion, skill, and personal perfection for both physician and clergyman. The opportunities for mutual service and mutual fulfillment should be enlarged.

THE CHAPLAIN IN THE LARGE HOSPITAL

WALTER T. GOUCH, CSP
Chaplain, Carroll House

THERE IS NO DUTY of the clergy that offers more opportunity for the fulfilment of a spiritual ministry than that of service in a large hospital. Here the chaplain or visiting cleric has an unparallelled opportunity to bring to men in their moment of greatest need the strength and the consolation of religious faith. To the sick and the dying he brings comfort and courage, the hope of recovery, or quiet acceptance of the inevitability of death. The power of prayer is his to impart not only to the patient but to the anxious relative or grieving loved one. As inspiration and example of devotion to duty he can bring added commitment to doctor and nurse. Working quietly and unobtrusively, slipping in and out of sick room or operating chamber, almost symbolizing the spiritual which he represents, he can add a dimension to the hospital that administrative efficiency and professional skills can never impart.

Medicine is not merely an art and a science; it is a ministry of healing that demands recourse to all of the possibilities of the human and to all of the power of the divine. Illness can be terrifying, pain demoralizing, death overwhelming; but known by all are the possibilities of renewal in the purification of pain, the brave acceptance of suffering, the illuminating potentiality of a long convalescence, moments or months that alert men once more to the possibilities of existence, when they look at themselves aright for the first or the only time in years. At such a time the man of God can be a mediator of the divine. But doctors and nurses, too, inspired by him or drawing on the depths of their own religious conviction, can assist in that conversion to a new personal and subjective existence by their belief in the divine, their religious-inspired charity, their loving concern for the personality of the patient, their offering to the Divine Physician of the carefully nurtured skill of their hands, and the laboriously transmitted and learned knowledge of their profession. The clergy must bring such a dimension to the hospital, to the ministering practitioners, and to the patient and his family. By his own devotion to the life of the spirit, he must bring a new vision of God, a profound faith, and a deep conviction of the goodness of the human and the greatness of the divine.

In recent years the medical profession, having made splendid advances on all fronts in its own field, has also become aware of the limitations of science and has become apprehensive of the impersonality that is overtaking the administration of medicine and the depersonalization that is inherent in the care of the patient by merely technical skills. This depersonalization not only is evident in the attitude toward the patient but it has its repercussion in the life of the physician as well. He loses his sense of being a person in fulfilling his role as a doctor. In his awareness of this, the doctor of medicine is turning for assistance not only to his colleagues in psychiatry but

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also to his otherwise disregarded or tolerantly accepted hospital-visiting clergyman. The clergyman must measure up to the needs and possibilities of the patient, but he must become increasingly aware of and competent to meet the needs of the doctor now ready to accept him as a colleague. The large hospital becomes a mediating agent in the new relationship of doctor and clergyman to each other and of their mutual relationship to the total need of the patient.

Until recently doctors and clergymen have not made sufficient use of the hospital to mutually aid one another in their care of the patient. Each has gone about his own task apart from the other, the clergyman either in awe of the doctor or disdaining him as competent perhaps in his profession (though not without doubts about this) but hardly competent in other areas, with rare but splendid exceptions; the doctor, in turn, regarding the clergyman with tolerant amusement, suffering his ministrations to the patient as sometimes effective, like magic but of little real significance, wondering at times about the profound effect it seems to have, but not bothering to think deeply about it. He rather hopes, insofar as he encounters the clergyman, that he will go about his task quickly and unobtrusively, causing as little disturbance of routine as possible. Though he would be pleasant at times, attracted by the personality of the particular clergyman, he often hesitates to speak lest he be subject to an attempt at "conversion."

The large hospital does not offer the same opportunity for breaking down this isolation as does the smaller and more homelike, if less efficient, institution. Yet in many places this is yielding to the spirit evidenced above. Either through the initiative of the doctors themselves or the administration, or through a resident co-ordinating chaplain, or through paid chaplains in residence, as in the large city or state or veterans' hospitals, increasing attempts are being made to effect more cooperation. In-hospital training of the clergymen, acquainting them with hospital routines and practices, periodic conferences of clergy and staff doctors, and instructing doctors, medical students, and nurses in the major tenets of the respective faiths and in their practices, particularly as they pertain to the hospital, have increased the mutual respect and cooperation. More of such education is demanded if the good of the patient is to be advanced.

Many clergymen complain that they are not sufficiently enlightened on the condition of the patient to enable them both to fulfill their own tasks more competently and to cooperate more effectively with the physician. Many of the clergy complain of the obstructionist tactics of interns and residents, so imbued with the power of their newly-exercised skills and so unaware of the capacities of others that they have no respect for the needs or sensibilities in the religious sphere of either patient or clergyman. Not that clergy are without fault, for often their unnecessary inferiority feelings before the reputation of medicine produces an aggressiveness which provokes the expected rejection. Both doctor and clergyman need more confidence in their respective skills and more humility in finding their sources in powers other than their own.

More friendly intercourse between clergy and medical practitioners and more understanding of the task of each would immeasurably aid the ministry of healing. The young doctors, at least, have to learn patients and families often are more concerned about relations to God and the requirements of religious belief, are more in need of peace or conscience, than of physical healing or the long postponement of death. Many a suffering patient, while welcoming the ministration of doctors and nurses, longs for the prayer of his minister or for the absolution and sacramental aids of his priest or rabbi. There are even those hardy souls left in the world who see a positive value in suffering as part of the redemption of their brothers as well as of themselves. To such the "last rites" are more important than a blood transfusion.

The hospital can assist the clergyman by calling him promptly in danger and by notifying him quickly in all instances. The keeping of proper records of religious affiliations, having them readily available to the visiting clergyman, and training its staff, particularly the head nurse on the floor, the resident in charge, and the central office or switchboard, to call the clergyman, particularly the priest, in proper time would help. Where there is a resident co-ordinating clergy-

man, with a competent secretary or an administrative assistant whose sole task is the co-ordination of clergy and hospital functions, there is little room for complaint. But instances are far too many of shoddy keeping of records, of personnel not sufficiently instructed, and of delays and inconveniences that lead to the neglect of the patient, great hurt to relatives, and resentment on the part of the attending clergy.

The procedure followed by some hospitals of having a central office, a competent secretary, quick forwarding of cards from the admitting office with the pertinent data, a quick filing of the cards under the titles of respective denominations, should be used by all hospitals, large and small. It would pay off in good will and more efficient service by the clergy. It would help too, not only to have cards with name, affiliation, nearest of kin, illness, age, and sex, but also to file them according to service and location, so that the visiting clergyman could go quickly to the proper place in an emergency and, on regular visits, plot his course through the hospital at a time most opportune for each patient, most convenient to the clergyman, and most suited to hospital routine. The clergyman in turn should leave a record for the hospital on the patient's chart in an emergency and at the central office in all instances, both of his time of visit and of his ministration, where that is pertinent. It is the practice in all Catholic rectories to keep such a record so that a call by the hospital can allay doubt at any time of whether or not a person has been seen by the priest.

There is hardly a large hospital any more that prevents access to members of the clergy to visit the patient at almost any time. This was not always true. The advantage taken of this by the clergy varies with denomination, the particular clergyman, and their accessibility. Practice, too, varies: the large denominational hospitals have resident clergy who visit all patients regularly and those in need more often. Daily visitation of each patient, if only for a few minutes, is not uncommon. At least one longer visit a week or at shorter intervals is common. The sacraments and prayers are readily available. Chapels are provided for the convalescent. Many of the public hospitals are providing the same services of resident chaplains and chapels, and even the denominational hospitals with a large number of patients of other convictions than their own are making their chapel available. More of this would help.

Where a resident chaplain is not present, the various denominations other than Catholic arrange for one of their clergy to make regular visits to all Protestant or Jewish patients. Improvement could be made by having such a ministry available in the evening hours and more readily accessible at night. The Catholic practice is to assign each hospital to the care of a particular parish, with one priest always "on duty," ready to receive a call, and with all in the rectory sharing in the visiting and daily ministration of the sacraments. Often one man, especially the youngest, is assigned the particular care of the hospital. In this way the young priest, guided by his elders, gets his training.

A particular problem that often arises is the visitation of members of one denomination by another or requests for instruction in or conversion to a particular religious faith. This can be effectively taken care of by proper training of the men involved in the hospital ministry and by regular meetings of all the clergy who minister to the particular hospital to set up recognized procedures.

Many denominations are engaged in deepening the religious conviction and practice of their respective communicants in the medical and nursing professions. Hours are assigned for services most convenient to them. Special sermons are directed to them where they are present in respectable numbers at day or evening services. Often they gather for prayer, instruction, or devotion in a hospital chapel or private room. Masses on Sundays and special days are provided for, with the use of hospital facilities where no chapel is available. Special evenings are set aside for prayer, services, bible devotions, hours of recollection or meditation, even whole days or weekends for retreats.

Of special significance is the establishment of Carroll House by the Archdiocese of Baltimore, under the direction of a board of Hopkins professors, with a small chapel, recreation room, library, and kitchen, exclusively for the doctors and medical and nursing students at the Johns Hopkins Medical Institutions. Carroll House has a resident chaplain whose sole charge is the spiritual ministration to and the instruction and guidance of the professor-student personnel in classes, lectures, and seminar. He has no care of patients as such. That and the regular services of religion to the total community, including the

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hospital, is left to the clergy of St. Andrew's. Together Carroll House and St. Andrew's give personal spiritual guidance to the hospital personnel; together they conduct the annual White Mass of dedication for all in hospital service. Similar, too, but organized as a parish, is the ministry of the Episcopal Church of Our Saviour; however, the devoted clergy there have a double ministry, that to the patient and that to the personnel, with services similar to those of Carroll House.

Carroll House is the first of its kind among Catholics in the United States. Not only is it a teaching and guidance center but it has the first research center ever set up in a Catholic student facility at a non-Catholic institution: the Cardinal Gibbons Center for the Study of Human Reproduction. Under a Joseph P. Kennedy, Jr. grant, a team of doctors and theologians from all parts of the United States and with affiliations in Europe and South America, under the direction of a Hopkins medical professor, is studying all of the medical, moral, and sociological factors involved in the problems of population. Significant here is the call to the medical profession to give of the best of its talents to the solution of a great human problem with theological dimensions. It is a prime example of the new role of the laity in the church.

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The chaplain's program at Washington County Hospital is very new but it has enjoyed rather remarkable growth and development through the three distinct stages described herein. It is the result of the planning and cooperation of the county council of churches, the mental health association, the hospital administration and staff, the county medical society, and the Department of Pastoral Care of the Brook Lane Hospital.

THE CHAPLAINCY PROGRAM IN A SMALL HOSPITAL

WILLIAM D. NOFZIGER, BD
Chaplain, Washington County Hospital

WASHINGTON COUNTY HOSPITAL is a 300-bed community hospital in Hagerstown. The chaplaincy program of this hospital has developed through three stages since its beginning with the decision of the County Mental Health Association to offer a scholarship to a local clergyman for special studies in the field of pastoral care. This proposal was endorsed by the county council of churches. Following this decision, a local clergyman took a six weeks course in pastoral care at the School of Pastoral Care, Baptist Hospital, Winston-Salem, N. C. Upon his return, in the spring of 1960, plans were carefully made for the establishment of a rotating volunteer chaplaincy program. The council of churches and the ministerial association offered encouragement and support. The hospital administration was sympathetic and cooperated fully with the developing plan. Interested physicians also assisted in the planning of the new program. The mental health association continued to stimulate interest by setting up a one-day workshop for physicians and clergymen in caring for the total needs of patients and parishioners.

VOLUNTEER CHAPLAINCY PROGRAM

The result of this initial interest and planning was that in January, 1962, the volunteer chaplaincy program was inaugurated under the direction of the chaplaincy committee. The committee was appointed by the county council of churches.

In this volunteer program, a community pastor volunteered to spend approximately two hours a day for one week in the hospital as chaplain. These volunteer clergymen were selected by the chaplaincy committee. They were expected to participate in at least three of the regular monthly chaplaincy workshops and to alert themselves to the needs of patients in the hospital. A psychiatrist from the county health department offered group therapy sessions to interested clergymen.

The purpose of the volunteer program from the beginning was not to take the place of the patient's own pastor but rather to make at least one visit with people having no religious affiliation or who were from outside of Washington County. The hospital administration assisted by making a copy of each new patient's admitting slip available to the chaplain's office. This information included

the patient's name, address, and religious affiliation, if known. Members of the Washington County Council of Church Women, in cooperation with the woman's auxiliary of the hospital, took responsibility to notify local clergymen immediately by telephone of their parishioners' admission to the hospital. Letters were sent to out of town clergymen, thus promoting good relationships with the various churches of the community.

The volunteer chaplain was also on call for emergency situations at the hospital. He could be called upon to minister to patients and family members in the crisis of accident, suffering, or death. The volunteer chaplains enjoyed good reception in the hospital for patients, nurses, and physicians.

CHAPLAINCY TRAINING PROGRAM

On August 1, 1963, a second dimension of the chaplaincy program was begun at Washington County Hospital. This involved a one-year pastoral training program. The training program was carefully considered and fully approved by the administration and the board of trustees of the hospital. It was sponsored by the Department of Pastoral Care of Brook Lane Hospital, Hagerstown, in collaboration with the Washington County Council of Churches through its chaplaincy committee. Brook Lane Hospital is a private psychiatric hospital. Its board and clinically trained chaplain are interested in the continuing education of clergymen. The training program was directed and supervised by the chaplain of Brook Lane Hospital. The purpose was to provide an opportunity for one year of intensive study and training in pastoral care for ministers. It was to 1) "Specifically further prepare a minister to fulfill his pastoral care and counseling ministries," and 2) "Generally complement his total theological education."

The pastor in training was called a "chaplain resident." He divided his time between the Washington County Hospital, the Western Maryland State Hospital for Chronic Diseases, and the Brook Lane Hospital. A salary of $5000 was made available by the three hospitals and the council of churches. His scope of training included the following:

1. Assist with the volunteer chaplaincy and be consultant to individual volunteer chaplains.

2. Accept referrals from physicians, chaplain volunteers, and community pastors and make referrals to community pastors and community agencies.

3. Provide pastoral care for patients and their families within the hospital.

4. Be available for emergency calls.

5. Conduct religious services, discussion meetings, and religious rites that are necessary for an effective ministry.

6. Develop communication between staff, physicians, and clergy.

7. Represent and relate the hospital to the county council of churches.

PERMANENT CHAPLAINCY POSITION

During the year's training program the Washington County Hospital Board of Trustees decided to establish a permanent chaplaincy position upon the recommendation of the chaplaincy committee of the county council of churches. At the same time, the county medical society passed a resolution endorsing the establishment of a chaplaincy position. On August 1, 1964, this third dimension of the chaplaincy program was inaugurated.

Also during the training year, the chaplain resident became certified as a professional hospital chaplain by the American Protestant Hospital Association. He was invited to accept the new permanent chaplaincy position. In this new position he spends four and one half days a week at the Washington County Hospital and the remainder of his time at the Western Maryland State Hospital for Chronic Diseases.

The job description for the new chaplaincy position includes the following statement of purpose adopted from the "Essentials of a Hospital Chaplaincy Program" (American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill. 60611, 1961).

1. "To make a religious ministry available to patients in conformation with their faith and expressed desire for pastoral counseling."

2. "To offer opportunity for coordination of clergy with the health team."

3. "To afford an opportunity for a close working relationship with all religious groups in the community and the hospital."

In order to carry out this purpose the chaplain's responsibility is divided into the following general areas:

1. *Pastoral Care to Patients.*—The chaplain is responsible for the coordination and direction of the volunteer chaplaincy program, in cooperation with the chaplaincy committee. The full time chaplain accepts referrals from physicians, nurses, and clergymen. He refers patients to community clergymen and churches or synagogues. He conducts a regular Sunday group worship service in the hospital. He makes available a religious ministry to individual patients upon their request, including baptism and holy communion. He is in call for emergency situations. An indirect ministry to patients sometimes involves working with anxiously waiting or grieving family members.

2. *Formal and Informal Counseling With the Hospital Staff and Student Nurses.*—He is identified with the hospital; yet because he is not a part of the supervisory structure, he can be of help in clarifying and understanding some personal problems and interpersonal relationships. He can assist in the communication and expression of feelings, thus promoting better working relationships.

3. *Education, Consultation, and Collaboration With Other Professional People and Groups.*—This involves planning and coordinating workshops for community clergymen. These regular workshops are being planned for clergymen in which physicians, professional social workers, and clergymen function as teachers and resource persons to enhance the pastoral care procedures of the participating clergymen. The chaplain also conducts classes for student nurses. He works with individual pastors on specific pastoral care problems that arise in his parish. He is also asked by individual clergymen for help with personal problems. He is called upon to act as a liaison between community clergy and physicians. He seeks to promote more adequate conversation between these two professions. He is developing a small library in the fields of religion and health, which is available to all professional people. He is a member of a local committee appointed by the county medical society to develop awareness of the relationships of religion and health.

4. *Marriage and Family Counseling on an Outpatient Basis.*—This involves working with families when referred by physicians or clergymen.

5. *Participating in Activities That Concern the Health and Welfare of the Community.*—He is called upon frequently to speak to church and civic groups as a representative of the hospital. He is a board member of the Hagerstown Family Service Agency.

PROBLEMS OF THE PROGRAM

The program is not without its weak points and problems. Among these are the following:

1. Some community clergymen are a bit suspicious of the chaplain's ministry. It is easy for some to view the chaplain as unnecessary or as some kind of threat to their own pastoral ministry.

2. There is the need to promote more awareness and better understanding on the part of more physicians as to how a trained chaplain may be of assistance to the total care of patients.

3. There is the problem of developing better understanding and communication of problems and feelings between the chaplain and the nursing personnel of the hospital.

4. There is the on-going concern to develop better and more adequate awareness and sensitivity to deeper human need on the part of community professional people.

5. There is need for continued clarification and study of the opportunities and the limitations of the chaplain's ministry in a community general hospital.

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Hagerstown, Maryland



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THE MARYLAND COUNCIL OF CHURCHES AND ITS RELATION TO THE PRACTICE OF MEDICINE

This organization of combined churches has demonstrated in many ways its readiness to work with the medical profession on problems of mutual concern.

MANFRED MANRODT, ThM
Chairman, Committee on Pastoral Services

The Maryland Council of Churches is an agency of the Protestant and Eastern Orthodox churches of the state. Its purpose is to bring to active expression the common concerns of these churches. Nineteen church bodies are members, and 14 additional church bodies are related to it. Through the Maryland Council of Churches, the Protestant churches cooperate with the Roman Catholic Church and the Rabbinical Council.

The Council of Churches arranges programs for the churches over radio and television. Through the Council, the viewpoint of the churches is expressed in newspaper articles, at public hearings, and through participation in other occasions of public interest.

One of the concerns of the Division on Christian Social Relations, and specifically its Department on Pastoral Services, is to provide an adequate Christian ministry of high professional standards to the sick in the various hospitals and institutions in Maryland. It is also charged with the distinct responsibility to establish close relations with the medical profession.

In order to appreciate the contribution of the church in the field of ministering to the sick, we must bear in mind the spiritual character of this Christian ministry and the fact that the Maryland Council of Churches is basically more than a service organization. The Council of Churches does more than bring an organization and its large body of professionally trained men into close working relations with the medical profession and the institutions in which and through which they operate. The Council of Churches, representing the total impact of the Christian churches and their clergy, supplies the spiritual character of the ministry to the sick.

In addition to the strictly human needs of patients, we recognize the mystical relationship between God and the believer. For this reason the church is more than a merely human agency. Our ministry to the sick, therefore, adds the spiritual insights of religion to the scientific ministry of the medical profession.

The Christian Church does not enter into working relations with other professions or agencies with the idea of converting others to her religious conception of life, as desirable as that may seem to a churchman. Nor do we expect the medical profession to make doctors out of pastors or public officials, as desirable as it may seem to have every one enjoy true scientific understanding. The Christian Church, however, through its individual representatives or its organized services, makes a contribution which is widely recognized as a vital necessity. Together with the medical profession, the church is endeavoring to serve the whole man, that is to serve the patient as a person rather than address itself to disease or physical handicap alone.

On the other hand, the Christian Church likewise recognizes the total need of the patient to comprise the care and healing of body and mind. Long before the Christian era, the religious believer recognized the need of scientifically trained

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men to meet the needs of the sick and the infirm. Note among many other illustrations the fine admonition in Ecclesiasticus:

> Honor a physician with the honor due unto him for the uses which ye may have of him; for the Lord hath created him. For of the most High cometh healing, and he shall receive honor of the king. The skill of the physician shall lift up his head: and in the sight of great men he shall be in admiration. (38:1-3)

For this reason the Christian Church in times past built hospitals and trained doctors and today readily supports the work of the medical profession and cooperates with it as opportunity affords. This is being done in two ways: first, by the endeavor to foster mutual understanding and appreciation, and, second, by joint ministrations.

The first is accomplished by special institutes and conferences, and the second by special services to patients who have entered institutions of healing. In the case of the clergy, their services and their special training are usually intertwined. We see this in the case of the Johns Hopkins Hospital, which has a highly developed visiting clergy service and offers an annual institute on ministering to the sick, which is open to all clergy.

This specific concern has resulted in the organization of visiting clergy staffs in an increasing number of hospitals by the Maryland Council of Churches.

The large and well organized staff at the Johns Hopkins Hospital came into existence independently but has maintained close cooperation with the Council of Churches throughout the years in various ways. Their first annual institute on ministering to the sick, as well as the overall plan for such institutes, to quote but one definite instance, was planned by an advisory committee of the hospital together with representatives of the Council of Churches. In these institutes, leading members of the medical profession are given the opportunity not only to tell of their own work but also to discuss with the clergy their mutual problems and their mutual expectations. The entire work of the Hopkins staff has been written up by me in 1955 in a brochure entitled *The First Fifteen Years of the Visiting Clergy Staff of the Johns Hopkins Hospital* (now out of print). Special recognition of the fine working relationship of the two professions is recognized throughout this publication. This is expressly stated under "Beginnings and Growth":

> From the very beginning and throughout the years which followed the Visiting Clergy Staff has received wholehearted cooperation and recognition by the Administration and the medical staffs.

Other institutes have been conducted under the auspices of the Council of Churches at the Washington County Hospital, and others, and in conjunction with local leadership at Baltimore City Hospitals, Spring Grove State Mental Hospital, and others.

Other visiting clergy staffs were organized by the Council of Churches at the Montebello State Hospital, Franklin Square Hospital, the Washington County Hospital, the Carroll County Hospital, Sinai Hospital, and others. In all of these it was made a regular part of the program to have the medical members of the respective hospitals meet with the clergy and arrange for discussion of patient and other professional problems.

All of these programs are shared with the Roman Catholic Church and the Synagogue.

The sharing of professional insights and interests as well as the discussion of specific or common problems in both the institutes and the regular staff meetings have proved most helpful to develop mutual understanding. The institute and staff meetings have met with enthusiastic response by both the doctors and the clergy.

In order to further illustrate the close cooperation between the medical profession and the Maryland Council of Churches, we refer to the history of the Red Cross Blood Assurance Program. Some years ago the problem of securing sufficient blood donations for surgical patients became acute, with no one able to establish an adequate program. The Maryland Council of Churches thereupon organized a citizens' group to establish a system by means of which the medical profession could be assured of an adequate blood supply for their patients. This has brought about the establishment of the Red Cross Blood Assurance Program, which is now functioning under Red Cross auspices with close medical supervision. This cooperative venture of joint sponsorship of the medical societies and the clergy has been duly recorded in *The Story of the Citizens' Blood Donor Committee,* which was written by me in September, 1958.

There has also been a direct exchange of in-

formation and a sharing of problems at the local level in Baltimore, when the Council of Churches' representative assisted the Medical and Chirurgical Faculty in setting up programs in 1963 and 1964 with panels alternately staffed by clergymen and by doctors. In December, 1963, physicians and clergymen were invited to review together areas of problems and concern in relation to total patient care. With Louis A. M. Krause, MD, serving as moderator, three clergymen, representing the three religious faiths, formed the panel. A year later, on October 8, 1964, another program on medicine and religion was held. This time a clergyman served as moderator and seven doctors made up the panel. There were no set speeches; the time was given over to a fruitful question and answer exchange.

Mutual interest and concern for each other's problems also came to expression when the use of animals in research was challenged some years ago. Through published statements, the Council of Churches officially backed the medical schools.

Whereas the field of close relations between the medical profession and the Council of Churches is by no means covered exhaustively in this article, enough has been said to establish the fact that there always was and still is a vital relationship of mutual understanding and respect between the two professions, even as there is a complementing of each other's services.

The clergy's ministry has been enriched and become more effective by a more intelligent approach to the patient's problems, which has been made possible by the doctors' willing contribution to the clergyman's education. By the same token, the clergy have often been able to serve as public relations intermediaries at the patient level, clearing up prejudices, referring their members to physicians or institutions, and in general building up the public image of their partners in the concern for the sick and the afflicted.

While all of this varies with the individual clergyman and the individual doctor, it is absolutely true that the combined clergy through the Council of Churches is always ready to foster mutual understanding and to cooperate in the problems of common concern. We also look to the medical associations and the hospitals to extend the churches and their clergy the hand of true fellowship.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

Physician's Guide to

RELIGIOUS PRACTICES OF MAJOR FAITHS

Whether they are called sacraments, ordinances, or rites, or by any other name, the religious practices observed by your patients may be of utmost importance to them in times of illness and approaching death.

We asked representatives of 19 major religious bodies to summarize briefly the practices of their faith, especially as they would relate to the doctor and his patient. Fourteen replied, and their statements are presented here in alphabetical order.

ASSEMBLIES OF GOD

The sacraments of the Assemblies of God are Water Baptism and Holy Communion.

Water Baptism by immersion is for those who have repented and believed; it signifies the beginning of a Christian life. It is an outward symbol of an experience that has already taken place in the believer's heart. By Baptism the believer is identifying himself with the death, burial, and resurrection of Jesus Christ.

Holy Communion signifies the continuance of the Christian life. It is the symbol expressing our sharing the divine nature of Christ and a memorial of His atonement. The elements consist of bread and wine (non-fermented). The bread symbolizes the broken body of Christ, and the wine symbolizes Christ's blood. Holy Communion is observed in most Assemblies of God churches the first Sunday of the month and is open for all believers present, even though not a member of this particular denomination.

H. Jack Morris
Pastor, Bethel Pentecostal Tabernacle
Baltimore, Md.

BAPTIST

Baptism and the Lord's Supper are the two ordinances of the Baptist Church. They are symbolic, but their observance involves faith, confession, self-examination, discernment, gratitude, dedication, fellowship, and worship. Baptism is to be administered by the church under the authority of the triune God and is the immersion in water of those who by faith have received Jesus as Saviour and Lord. In that act the believer is portrayed as buried with Christ and raised with him to walk in newness of life.

The Lord's Supper, observed through the symbols of the bread and the cup, is a sober searching of one's heart, a thankful remembrance of Christ and his sacrificial death on the cross, a blessed assurance of his return, and a joyous fellowship with the living Christ and his people.

Baptism and the Lord's Supper, the two ordinances of the church, are symbolic of redemption, but their observance involves spiritual realities in personal Christian experience.

Roy D. Gresham
Executive Secretary-Treasurer,
Baptist Convention of Maryland

CHRISTIAN SCIENCE

Baptism is continuing repentance and moral and spiritual regeneration. Communion is entering into the meaning of Jesus' life as totally as possible in the context of one's own life, thus healing the sick, finding the meaning of the cross, the resurrection, the new perspective on reality given in Jesus' words (Luke 17:21): "The kingdom of God is within you."

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There is no sacramental ritual in the Christian Science Church. However, Communion and Baptism remain important in Christian Science theology. The emphasis is on the inward spiritual experience rather than on the outward sign. In church services twice yearly the congregation kneels in silent communion.

Lloyd E. Contant
Committee on Publication for Maryland

CHURCH OF THE BRETHREN

The Church of the Brethren from its inception has practiced the sacrament of the anointing for healing. The healing ministry of Jesus and the words of James 5:13-16 form the background for this sacrament.

The sick are to call for the clergy of the church to administer the sacrament of anointing. The sacrament includes the anointing with oil in the name of the Lord: for the forgiveness of sin, for the healing of the body, and for an increase of faith. The sacrament concludes with the laying on of hands accompanied by prayer.

The Church of the Brethren believes that the physical, mental, and spiritual being of man is interwoven. Therefore the sacrament does not in any way replace the role of medical science but rather seek to ally itself with medical science. The physician and the clergyman are allied together in the healing ministry.

Wilmer Q. Crummett
Executive Secretary
Eastern Maryland and Mardela Districts

CHURCH OF GOD

The two sacraments usually adhered to by Protestants, the Lord's Supper and Baptism, we do not call sacraments, but ordinances. The Lord's Supper is open to all Christians and is offered at least once or more times a year. Usually on the Thursday before Good Friday, the Lord's Supper is accompanied with a service of Foot Washing, at which time men and women go to separate rooms and wash each other's feet, in remembrance of Christ in the Upper Room.

Baptism is by immersion, signifying the "death and Resurrection" of the Lord, and the "Spiritual death to sin, and the Resurrection to a new life in Christ." It is administered to the person who has been "born again" through conversion to Christ. Thus, we do not baptize infants.

Neither ordinance is a "must" but an "ought to have done."

Arthur F. Bebee, Pastor
First Church of God
Federalsburg, Md.

DISCIPLES OF CHRIST

The Christian Church (Disciples of Christ) recognizes two sacraments, the Lord's Supper and Baptism. The Lord's Supper is celebrated in all our churches as a part of the regular worship service on each first day of the week. It is an act of remembrance and a symbol of the Unseen Presence, a preachment of the central theme of Christianity, sacrifice, and an assurance of the forgiveness of sins. It may be and is often presided over by laymen.

Baptism, according to the belief of the Disciples of Christ, is performed upon repentant believers in Christ only. While ceremonies of blessing of infants and dedication of parents are held for small children, the act is not to be confused with baptism. Baptism is performed by immersion after the most ancient practice and is regarded as a symbol of the death, burial, and resurrection of Christ in which the believer identifies himself.

J. J. VanBoskirk
Executive Secretary
Capital Area Association

EASTERN ORTHODOX

No response.

EVANGELICAL UNITED BRETHREN

The Evangelical United Brethren Church observes two sacraments, namely, Baptism and the Lord's Supper (commonly called Holy Communion). From the psychosomatic standpoint, both have therapeutic value.

Baptism symbolizes a cleansing from sin, and then membership in the family of God. Thus, a sincerely baptized person would be free from the enervating influences of guilt feelings. He would enjoy the healthy and positive attitude of con-

fidence in the face of extremity. Faith has always been a great asset in the alleviation of illness.

The Lord's Supper is a token of the love which Christians have for God in Christ and also for one another. Here the believer acutely senses his oneness with God, his Creator. And through this feeling of unity with Almighty God, the awareness of his own personal worth is enhanced. Also, he feels a unity and fellowship with others who worship and believe as he does. These convictions afford a wholesome attitude of calmness, serenity, and poise in all of life, and especially in times of extremity and illness.

Frederick W. Mund, DD
Pastor, Dorguth Memorial Evangelical United Brethren Church
Baltimore, Md.

FRIENDS

No response.

JEHOVAH'S WITNESSES

Jehovah's Witnesses adhere to the Bible as the inspired Word of God which contains the Creator's laws that mankind are required to obey. They practice two ceremonies in connection with their worship, Baptism by total immersion in symbol of dedication to God, and celebration of the Lord's evening meal in commemoration of the death and resurrection of the Lord Jesus Christ. Both of these practices are commanded in the Bible.

Since their dedication is unreserved, Jehovah's Witnesses regularly assemble for worship and actively preach from house to house in the manner of Jesus and his apostles. Jehovah's Witnesses realize that the time of the end is now here and that the present generation will see a culmination of God's purpose in the destruction of the present system of things which will usher in the peaceful thousand-year reign of Christ Jesus. This impels them to an urgency in their preaching, and they work diligently.

Among Christian obligations they observe is the command to abstain from blood. (Acts 15:20, 28, 29). Their relationship with God is a primary concern because it involves their everlasting life. The doctor who understands this viewpoint will much better understand his patient who is one of Jehovah's Witnesses.

Watchtower Bible and Tract Society of New York, Inc.

JEWISH

The physician treating his Jewish patients should be aware of some of the religious practices of the observant Jew:

The Dietary Laws.—Nowadays it is a simple matter to obtain Kosher food for Jewish patients desiring it by having the dietitian of the hospital obtain frozen meals prepared in accordance with the dietary laws.

Sabbath and Festival Lights.—The observant Jewish woman welcomes the Sabbath on Friday night with the kindling of Sabbath lights. The same is true on other festivals. Nowadays electric candelabra are available for this purpose so as to do away with the possible danger of lighting candles in hospital rooms.

Rituals Connected with Birth.—The Jewish male child is to be circumcised on the eighth day following his birth, if the child is normal and well. This follows the Biblical tradition and is called the Covenant of Abraham. This ritual should be performed by a specially trained Jewish religious functionary who is called a "Mohel." At this ceremony the Jewish male child is given a name.

A newly born Jewish girl is given her name at the Synagogue service in the presence of the father, who is called to the Torah sometime after the birth of the child.

Rituals Connected with Death.—There are no sacraments in Judaism to be administered by a religious functionary, either any time during one's lifetime or at the time of death. Judaism may be called a "do-it-yourself" religion. A sick person, sensing the approach of death, therefore, if capable of doing so, can recite the ancient Hebrew confession of faith, "Hear O Israel the Lord our God is one." If he is incapable, someone in the family standing by may recite this prayer with the dying person. Of course, if a Rabbi can be present he can lead the family in some suitable prayer of comfort or read an appropriate Psalm.

Dr. Israel M. Goldman
Rabbi, Chizuk Amuno Congregation
Baltimore, Md.

LUTHERAN

The Lutheran Church holds that there are two sacraments, The Lord's Supper and Baptism.

By definition, a sacrament contains an earthly material, a divine command, and a heavenly

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promise. Martin Luther stated it is "An outward sign of an inward Grace."

The Lutheran Church believes that the earthly material, whether it be bread or water, when comprehended in God's Word, becomes efficacious. It believes that the sacrament is a channel through which God's Grace flows to the recipient. It believes that in the sacrament God bestows to the recipient forgiveness of sins, eternal life, and deliverance from evil.

The Lutheran Church does not attempt to rationalize or explain how God's grace is made available but accepts these benefits in faith.

J. Frank Fife, DD
President, Maryland Synod

MENNONITE

The Mennonite Church has seven sacraments, which are termed as ordinances, one of which is related to the physical, which is stated as follows: We believe that anointing with oil should be administered to the sick who call for it in faith. This is practiced to some extent among our own members and is based on the scripture found in James 5:14-16. This does not mean we do not make use of physicians. We do believe we should make use of the knowledge and means available to us, but our trust is not as much in the physician but in the Lord using him.

Melvin Delp
Pastor, Mennonite Church
Baltimore, Md.

METHODIST

The Articles of Religion for The Methodist Church provide for two sacraments only, Baptism and the Supper of the Lord. They are designated sacraments because we believe they were ordained of Christ.

Sacraments ordained of Christ are "Certain signs of grace and God's good will toward us, and doth work invisibly in us, and doth not only quicken but also strengthen and confirm our faith in Him."

Baptism is a sign of regeneration or the new birth.

The Supper of the Lord is not only a sign of the love that Christians ought to have among themselves and to one another, but also is a sacrament of our redemption by Christ's death.

The body of Christ is given, taken, and eaten in the Supper, only after a heavenly and spiritual manner, and the means whereby the body of Christ is received and eaten in the Supper is faith.

Without doubt, these sacraments, when given and observed in times of illness, have a beneficial effect upon the patient and often result in a diminution of fear, leading to a restoration of physical health and well being.

John Wesley Lord
Bishop, Washington Area

PRESBYTERIAN

No response.

PROTESTANT EPISCOPAL

No response.

ROMAN CATHOLIC

No response.

SEVENTH-DAY ADVENTIST

Seventh-day Adventists usually use the term ordinance in place of sacrament, but the ideas popularly applied to the sacraments are in a general sense the same as those concepts held by Adventists to apply to the ordinances.

Adventists practice the ordinances of Baptism, Humility or Foot-washing, Communion, Marriage, and Prayer and Anointing of the Sick. Three of these would concern the physician and his patient. Communion is celebrated with unfermented, unsweetened grape juice and unleavened bread. The Prayer and Anointing service is conducted by the ministers' placing their finger tips, which have been dipped in olive oil, on the forehead of the patient during the prayer. The last is Baptism, which is by immersion.

Raymond M. Spencer
Pastor, Baltimore First
Seventh-Day Adventist Church
Baltimore, Md.

UNITARIAN AND UNIVERSALIST

There are no sacraments, *per se*, if you are using the word in its usual and ecclesiastical sense. Unitarians and Universalists do not gen-

erally hold to the idea that there are any mystical rites or practices which in and of themselves convey a sense of grace or union with God or which have special efficacy in promoting either health or salvation.

We are, however, great believers in the efficacy of sound mental health practices, goood medicine astutely practiced, and empathetic human relationships deeply shared. We do, therefore, place great emphasis upon the help that man can yield to man and expect that physicians and medical facilities generally will make every effort to facilitate communication between patient and his minister and his religious community.

Philip Randall Giles
Executive Secretary, Joseph Priestly District of Unitarian Universalist Societies

Subcommittee on Medicine & Religion

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Average Adult Daily Dosage: four divided doses of 1 capsule each or two divided doses of 2 capsules given at least one hour before or two hours after meals.

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Nasal congestion? Dimetapp lets your stuffed-up patients breathe easy again. Each Dimetapp Extentab works hard for up to 10-12 hours to open up congestion. And, with little likelihood of adverse reactions. Indeed, side effects with the antihistamine in Dimetapp-Dimetane® (brompheniramine maleate) were found in one investigation to be as few as with placebo.[2]

1. Clinical report on file, Medical Department, A. H. Robins Co., Inc.
2. Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959.

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

See product literature for complete prescribing information.

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ROBINUL® FORTE glycopyrrolate 2 mg. per tablet

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glycopyrrolate 2 mg. / phenobarbital 16.2 mg. / (warning: may be habit forming)

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Epstein[1] found glycopyrrolate's intensive antisecretory action to be exemplary. Breidenbach[2] was impressed by its pronounced antispasmodic effects. And Young and Sun[3] reported that a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time. . . ." According to Slanger[4], the absence of annoying side effects is an important plus factor ". . . for it permits ready individualization of dosage for control of mild to severe symptoms." Posey[5] sums it up when he says, "In effect, with glycopyrrolate, one approaches an ideal agent for the management of peptic ulcer. With it a vagolytic effect may be obtained without interfering with gastric emptying—the medical equivalent to vagectomy plus an adequate drainage procedure."

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BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

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Robinul®-PH (glycopyrrolate 1 mg. per tablet)
phenobarbital 16.2 mg.
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REFERENCES: 1. Epstein, J. H.: Am. J. of Gastroent., 37:295, March, 1962. 2. Breidenbach, W. C.: Investigative Clinical Report, March, 1961. 3. Young, R., and Sun, D. C. H.: Ann. N. Y. Acad. Sc., 99:174, Feb., 1962. 4 Slanger, A.: Journal of New Drugs, 2:215, July-Aug., 1962. 5. Posey, E. L., Jr.: Am. J. Dig. Dis., 7:863, Oct., 1962.

167TH ANNUAL MEETING MEDICAL AND CHIRURGICAL FACULTY

THE ALCAZAR, BALTIMORE
Unless otherwise indicated

WEDNESDAY, APRIL 21

AM

9:30 HOUSE OF DELEGATES
All members welcome

10:00 Exhibits open

PM

2:00 HEALTH EVALUATION TESTS
Charles S. Petty, MD
Assistant Medical Examiner, State of Maryland

2:15 SURGICAL MANAGEMENT OF GASTROINTESTINAL HEMORRHAGE IN PATIENTS WITH HEREDITARY HEMORRHAGIC TELANGIECTASIA
J. M. T. Finney Fund Lecture
Howard A. Patterson, MD
Columbia University

3:00 POPULATION CONTROL: WHERE DOES THE PHYSICIAN FIT IN?
I. Ridgeway Trimble Fund Lecture
Franklin T. Brayer, MD
Georgetown University

4:00 DIAGNOSIS AND TREATMENT OF PULMONARY EMBOLISM
Standish McCleary Fund Lecture
David C. Sabiston, Jr., MD
Duke University

8:30 THE CHANGING PATTERN OF MEDICOLEGAL ACTION
A Medicolegal Symposium
G. C. A. Anderson, Esq.
William D. Macmillan, Sr., Esq.
Belden R. Reap, LLB, MD

THURSDAY, APRIL 22

AM

9:00 Exhibits open

9:15 RECENT STUDIES IN HYPOPITUITARISM
E. Perry McCullagh, MD
Cleveland Clinic

10:00 VIRAL HEPATITIS
William Royal Stokes Memorial Fund Lecture
George S. Mirick, MD
New York University

11:00 TREATMENT OF RESPIRATORY INSUFFICIENCY
George M. Boyer, MD Fund Lectureship
Carl Muschenheim, MD
Cornell University

12:30 p.m. **ROUND TABLE LUNCHEON**
Park Plaza Hotel
24 tables with prominent physicians leading discussions on recent advances in medicine

PM

2:15 THE RHEUMATOID HAND
Lee Ramsay Straub, MD
Cornell University

3:00 RECENT ADVANCES IN UROLOGY AND THEIR RELATION IN GENERAL PRACTICE
Theodore R. Fetter, MD
Jefferson Medical College

4:00 THE CARCINOMA-IN-SITU STORY
J. Mason Hundley Annual Lecture
Richard W. TeLinde, MD
The Johns Hopkins University

A detailed program will be mailed to all members and to others upon request
NO REGISTRATION FEE

OF THE STATE OF MARYLAND APRIL 21, 22, 23, 1965

THURSDAY EVENING
Sheraton-Belvedere Hotel

6:15 **RECEPTION** 7:15 **PRESIDENTIAL DINNER**

8:30 Presidential Address
Albert E. Goldstein, MD
followed by
SPECIAL ENTERTAINMENT

FRIDAY, APRIL 23

AM

9:00 Exhibits open

9:15 DIAGNOSIS AND TREATMENT OF HYPERTENSIVE STATES
Harvey Grant Beck Memorial Lecture
Thomas B. Connor, MD
University of Maryland
R. Patterson Russell, MD
The Johns Hopkins University

10:00 EFFECT OF AGING ON DIAGNOSIS AND TREATMENT OF HEART DISEASE
Jesse C. Coggins Fund Lecture
Thomas W. Mattingly, MD
George Washington and Georgetown Universities

11:00 SELECTED ASPECTS OF GOUT AND GOUTY ARTHRITIS
John H. Talbott, MD
Editor, Journal of the American Medical Association

PM

2:00 HOUSE OF DELEGATES
Faculty Building
All members welcome

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Richard T. Shackelford, M.D., Chairman
Committee on Program and Arrangements

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(American Medical Political Action Committee)

Dear Colleague,

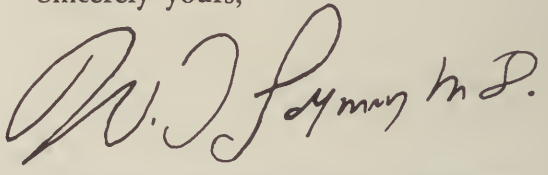
Please accept a most cordial invitation to be present at a breakfast meeting of the Maryland Medical Political Action Committee and to hear an outstanding speaker, Edward R. Annis, MD, Past President, American Medical Association. His topic will be a timely one in relation to medical legislation.

THE BREAKFAST MEETING WILL BE HELD ON THURSDAY, APRIL 22, 1965, AT THE SHERATON BELVEDERE HOTEL, CHARLES AND CHASE STREETS, BALTIMORE AT 7:45 AM

The meeting will end in time for you to attend the Annual Meeting of the Medical and Chirurgical Faculty at the Alcazar at 9:15 am

For a reservation and ticket please cut out reservation form and return to Mrs. Raymond L. Markley, 707 Thornwood Court, Baltimore, Maryland 21204. Upon receipt of your check, your tickets will be mailed to you.

Sincerely yours,



William T. Layman, MD, Chairman
Maryland Medical Political
Action Committee

Tear-off and return promptly with your check, made payable to Maryland Medical Political Action Committee, to

Mrs. Raymond L. Markley
707 Thornwood Court, Baltimore, Maryland 21204

Enclosed is my check made payable to Maryland Medical Political Actian Cammittee (MMPAC) for $..... for ..... reservatians, ($2.50 per person) for the breakfast at the Sheratan Belvedere Hotel at 7:45 AM on Thursday, April 22, 1965.

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REMINDER FOR YOUR CALENDAR →

MMPAC BREAKFAST

THURSDAY, APRIL 22, 1965

7:45 AM

SHERATON BELVEDERE HOTEL
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Baltimore

COMPONENT MEDICAL SOCIETIES

ALLEGANY COUNTY

REHABILITATION OF THE BLIND IN ALLEGANY COUNTY

Allegany County Workshop for the Blind is one of two in the state, the other being located in Baltimore City. The Cumberland, Allegany County Workshop for the Blind was established by an act of legislature in 1957, almost 50 years after the establishment of the one in Baltimore.

Twelve to 15 blind persons receive training on a part time basis in their own homes. They are taught braille, sewing, typing, knitting, and cooking. Currently six blind people between the ages of 19 and 39 are receiving full time rehabilitation training in and out of the Workshop for the Blind.



Two of these are attending institutions of higher learning outside of Cumberland, while one is being trained within the Workshop for the Blind.

The leading causes of blindness in Allegany County are about equally divided between diseases primarily in the eye itself and complications from other diseases. Accidents are a third cause.

At the present time, 19 persons are receiving a blind pension in the county. The funds for this are appropriated by the county, state, and federal governments on a 20-20-60 per cent pro rata basis. The basic blind pension is $43.50 per month with a rent allowance of $35.

All blind persons owning real estate are ex-

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empted from paying taxes up to the amount of $6,000 per person. Five such persons were granted this exemption in the past year in Allegany County. To qualify as blind a person must not be able to see more than 20/200 in the better eye and the peripheral field must be contracted to 20 degrees or less in its widest diameter.

The county is equipped to rehabilitate more than the number now availing themselves of the facilities. It would seem that prevention of blindness should be a major part in the program of rehabilitation.

NEW OFFICERS

William P. Iames, MD, Cumberland, has been elected president of the Allegany County Medical Society for 1965. Other officers are: vice-president, **David H. Miller, MD,** Cumberland; secretary, **L. Michael Glick, MD,** Cumberland; and treasurer, **Samuel G. Weisman, MD,** Cumberland.

Leslie E. Daugherty, MD, continues as JOURNAL representative.

PERSONALS

R. Rhett Rathbone, MD, addressed the Future Nurse's Club of Southern High School, Oakland, showing slides on cancer and answering questions. Two other Cumberland physicians spoke at local high schools: **Ralph W. Ballin, MD,** and **Calvin Y. Hadidian, MD,** with a film showing of "Is Smoking Worth It?"

Dr. and **Mrs. Wyand F. Doerner, Jr.,** announce the birth of a son, Robert Michael, on December 30.

Every man beareth the whole stamp of the human condition.
—Montaigne

Leslie E. Daugherty, MD

ANNE ARUNDEL COUNTY

The Anne Arundel County Medical Society met at the Coachman Inn on Ritchie Highway on December 16. Approximately 40 members attended the meeting.

Mr. John Sargeant, executive secretary of the Medical and Chirurgical Faculty, was our guest and after dinner spoke briefly on society matters. **Martin Middleton, MD,** chairman of the Faculty's Legislative Committee, our guest also, told the members that the Faculty is trying to implement the Kerr-Mills program more fully in Maryland. Dr. Middleton furthermore informed us that the AMA is still highly in favor of the Kerr-Mills plan. He requested that the president of our society appoint a congressional contact committee to continue to contact members of Congress concerning our opposition to government intervention on the practice of medicine.

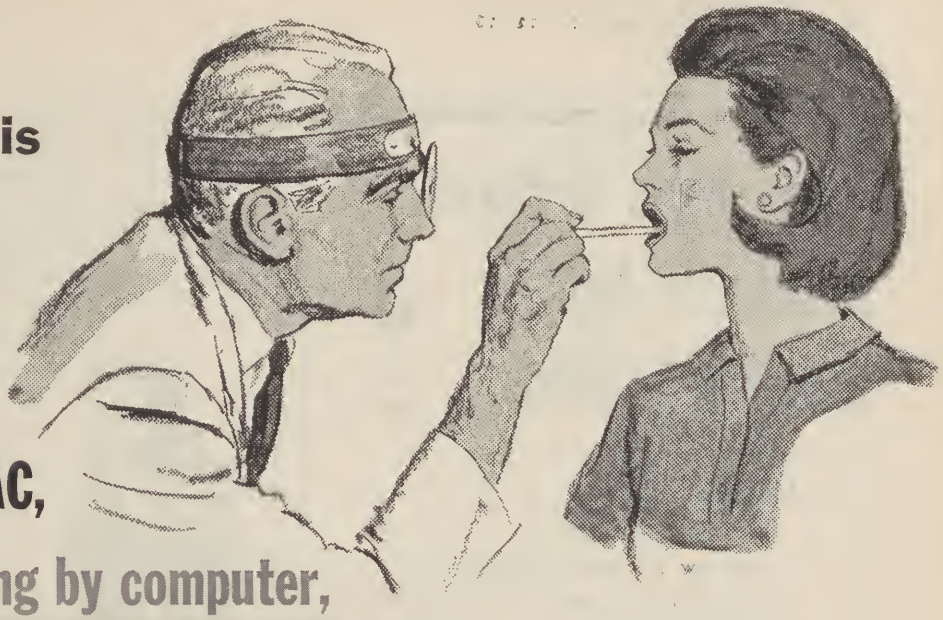
After the talks by Dr. Middleton and Mr. Sargeant, the regular business meeting was held. The society unanimously approved a donation of $50 to the Student American Medical Association.

Raymond Srsic, MD, Program Committee chairman, announced plans for the January meeting, to be held at Carvel Hall, Annapolis, jointly with the Anne Arundel County Bar Association.

James Hudson, MD, chairman of the Public Relations Committee, **Philip Briscoe, MD,** and several other members discussed the establishment of emergency coverage throughout the county through the medium of the press, radio, and TV. Several members commented that many physicians need to be educated on this matter, as well as the general public. It was recognized that some physicians are not conscientious about arranging coverage when they are away and, furthermore, are not reliable when it is their turn to be on emergency call.

William Williams, MD, of the Nominating Committee, announced the following nominations for 1965: president, **Samuel Borssuck, MD,** Annapolis; vice president, **George W. Settle, MD,** Annapolis; secretary, **H. Logan Holtgrew, MD,** Annapolis; treasurer, **Antonio Rivera, MD,** Edgewater; Board of Directors (for two years), **Hilary O'Herlihy, MD, Ernest Leipold, MD,** and **Leon Perry, MD,** all of Glen Burnie; delegate to the Medical and Chirurgical Faculty, **Merton C. Waite, MD,** Annapolis; alternate delegate, **Hubert F. Manuzak, MD,** Glen Burnie; delegate to the Planning and Policy Committee of the Medical and Chirurgical Faculty, **William A. Williams, MD,** Annapolis; alternate delegate to the Policy and

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Planning Committee, **Julius Loebl, MD,** Glen Burnie. All were unanimously elected.

Two new members were received: **Francis Kopack, MD,** who will practice pediatrics in Annapolis, and **Ernesto Tolentino, MD,** who will practice general surgery in Glen Burnie.

Randall M. McLaughlin, MD



BALTIMORE CITY

Medicine on Wheels (or Medicarriage?) is a plan devised by Charles Flom, MD, to bring emergency medical services to patients. It consists of a specially equipped mobile unit manned by a technician and a registered nurse. The equipment in the mobile unit would include electrocardiograph, x-ray and blood count apparatus, and a phototransmitter. In this way the paramedical emergency team can perform many services usually done by a physician and transmit them to a designated hospital, which would act as a monitoring center under the supervision of a physician.

Dr. Flom believes that this emergency team can bring medical services to people not served by a physician and relieve some of the excess load on hospitals and hospital accident rooms.

The mobile unit is being assembled and will soon be tested, with the cooperation of two Baltimore hospitals.

Joseph D. B. King, MD

BALTIMORE COUNTY

The Baltimore County Medical Association held its January meeting at the state medical society headquarters.

Samuel Scalia, MD, reported that the food handlers x-ray program had detected 57 cases

of tuberculosis, which included seven active cases. Dr. Scalia further stated that the x-ray program will be done every three or four years instead of yearly as originally planned.

Charles Williams, MD, reported that the Baltimore County General Hospital is badly needed in the Liberty Road area and that the residents in that area are doing everything they can to keep the hospital functioning, with Blue Cross approval. **Jonas Rappeport, MD,** proposed that we go on record as understanding that the Baltimore County General has been established as a non-profit hospital in Baltimore County and that its need is widespread. As a result of our limited investigation, we understand that it is being run by men of good medical character and that we again go on record as supporting this hospital in its establishment in Baltimore County. He further stated that we are concerned about the economic power that is inadvertently being placed in the hands of the Blue Cross program, as it becomes clear that the financial problem which this hospital claims it is suffering is a result of its not being approved as a participating hospital by the Blue Cross program. The motion was seconded and carried.

Donald Roop, MD, chairman of the Board of Governors, reported that *Today's Health* will be sent to the schools in Baltimore County on a nine-month basis rather than yearly as stated in the original motion.

The following former members of the Baltimore City Medical Society were elected active members of our association by transfer: **John C. Norton, MD, Bernard Byrnes, MD,** and **Jose Valderas, MD.**

Mary Matthews, MD, of the Baltimore County Health Department, reported that the Planned Parenthood Association has set up two clinics in Baltimore County, one in Catonsville and the other in Essex, and that the Planned Parenthood Association is carrying out the program but using Health Department facilities.

John Sargeant, executive secretary of the Medical and Chirurgical Faculty, gave an interesting report on the legislative program which will be introduced during this sesson of the state legislature.

Charles H. Williams, MD

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Andrew C. Mitchell, MD, new president of the Wicomico County Medical Society, Inc. Dr. Mitchell is former president of the Maryland Academy of General Practice and past chief of the Department of General Practice, Peninsula General Hospital, Salisbury.

Robert V. Campbell, MD, Maryland delegate to the AMA House of Delegates, presented $9,526.00 to R. M. McKeown, MD, president of the AMA-ERF Board of Directors, as the Maryland contribution to the funds for medical schools program. The presentation was made at the recent AMA Clinical Meeting in Miami Beach.



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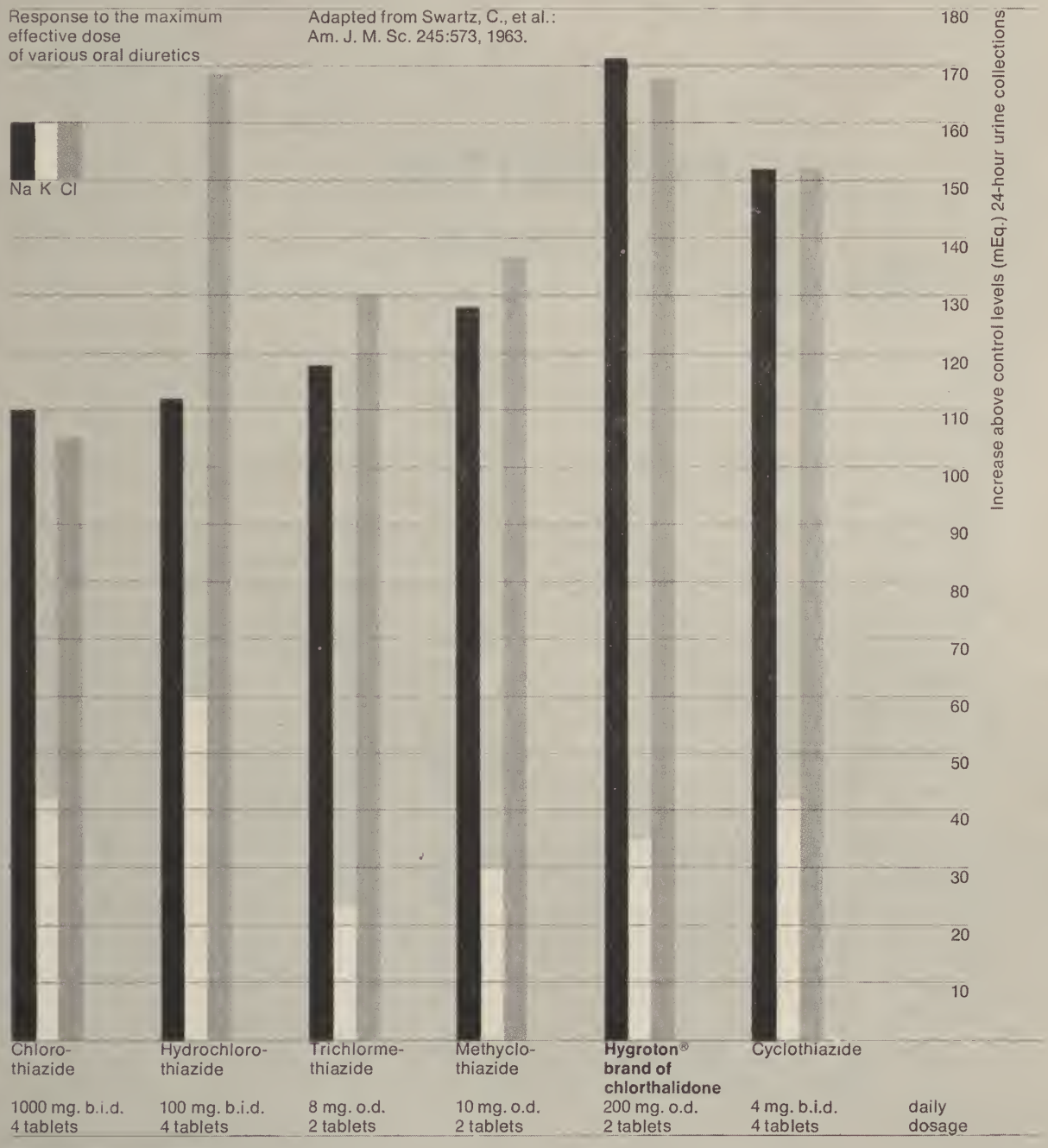
Geigy

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity, and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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With PENBRITIN (ampicillin) the emergence of resistant strains of organisms is *slow* rather than rapid as with other antibiotics.[1,2] Tetracycline-resistant hemolytic streptococci and pneumococci have been reported[3-6]—but this has not been a problem with PENBRITIN (ampicillin). According to an editorial in *Lancet*,[2] PENBRITIN (ampicillin) could be particularly valuable in *killing* coliforms and *Proteus*, which may otherwise quickly become resistant during treatment. Recently, several *Shigella* strains, resistant to tetracycline, chloramphenicol, and other antibiotics, were found to be susceptible to ampicillin.[7]

Dosage: Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.*: Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.*: New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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1964 REPORT

On Activities of The Maryland Society of Pathologists

PART I

AS RETIRING PRESIDENT, it is my pleasant task to summarize some of the major activities of the Maryland Society of Pathologists during 1964.

Physicians are becoming increasingly aware of the impact of rapid technologic, socio-economic, political, and legislative changes which directly or indirectly affect their efforts to provide quality medical care at reasonable cost. We recognize our obligation to take an interest in these areas and to give advice and counsel in matters affecting the health and welfare of all the people. Past experience has shown that in areas where a vacuum is created by lack of participation and interest by the physicians, it is often filled by leadership unaware or disinterested in the need for professional freedom and medical ethics which has served the people of the United States so well for so long.

In the specialty of anatomic and clinical pathology (or laboratory medicine), numerous perplexing problems and controversial issues have developed. One of our major goals has been to strengthen the structure and function of the council of the Maryland Society of Pathologists. The council transacts the general executive and financial business of the society and determines its policies with the approval of the membership. The society must serve the needs of all of the disciplines, whether they be associated with the academic, governmental, institutional, or private practice of pathology.

I am pleased to report that many of our most respected and competent colleagues have given time from their busy schedules to serve on this council. I wish to recognize them and express the appreciation of the society. From the medical schools: Harlan Firminger, MD, professor and chairman, Department of Pathology, University of Maryland Medical School; Ivan Bennett, MD, professor and chairman, Department of Pathology, Johns Hopkins Medical School (councilman-at-large-elect); John Frost, MD, associate professor of pathology, Johns Hopkins Medical School. From the hospitals and private practice: Paul Guerin, MD, Watson Kime, MD, William Lovitt, MD, Robert Lancaster, MD, George Blundell, MD (past president). From the government: Louis Thomas, MD, National Institutes of Health; Charles Petty, MD, assistant medical examiner, State of Maryland; Robert Cavenaugh, MD, director of laboratories, Maryland State Department of Health (councilman-at-large-elect). I think that all will agree that we recruited the best available talents and provided balance so we could address ourselves to the many problems which faced us.

The council purchased files and a mimeograph machine to keep records systematically and to improve communication with the membership. The constitution was revised so that the past presi-

ROBERT Y. KATASE, MD
Past President
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dent, utilizing his experience of the past year, could serve as an ex officio member of the council. Paul Guerin, MD, was appointed historian to properly preserve the records. Liaison and communication channels with the College of American Pathologists, the Medical and Chirurgical Faculty, the American National Red Cross, the Pathology Section of the Baltimore City Medical Society, and the State Department of Health were strengthened, resulting in many successful cooperative efforts which opened the door for developing new avenues of complementary action to the mutual benefit of the respective organizations.

One of the most successful activities was the sponsorship of a Pathology Resident Workshop with the College of American Pathologists, held in conjunction with an excellent scientific program and co-sponsored with the Pathology Section of the Baltimore City Medical Society and the Washington Society of Pathologists. It culminated with a slide seminar on "Pathology of Arthritis and Rheumatism," given by Leon Sokoloff, MD, from the National Institutes of Health. More than 150 pathology residents from Maryland, the District of Columbia, Virginia, Pennsylvania, and North and South Carolina attended this two-day seminar on the socio-economics and administrative problems of pathology, which was presented by an authoritative faculty drawn from all over the United States. The faculty included Victor Buhler, MD, and Donald Nickerson, MD, president and past president of the College of American Pathologists, respectively. The participants were unanimous in their appreciation of the scope, breadth, and balance of the type of information to which they are not ordinarily exposed during their resident years. (To be continued)

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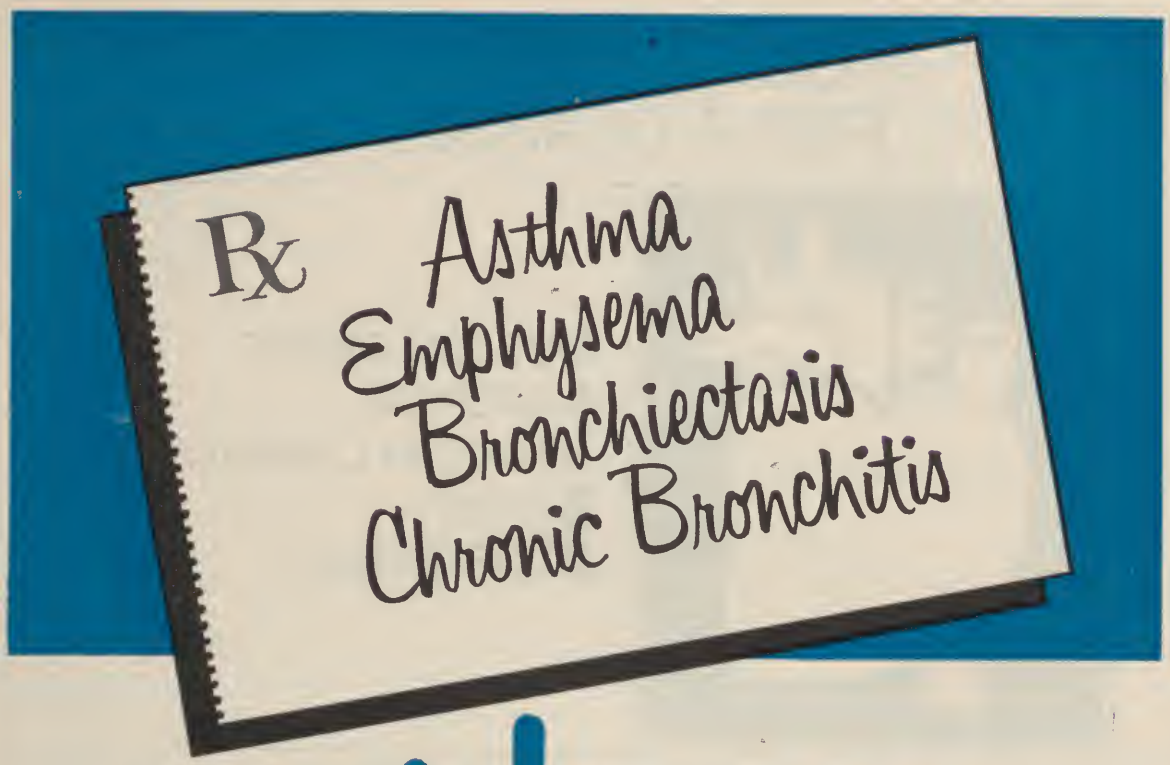
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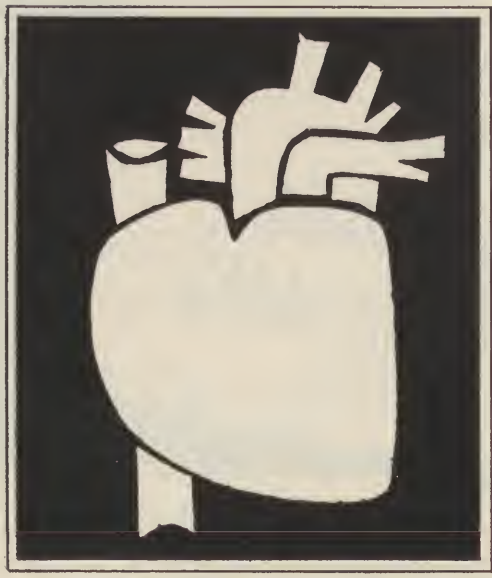
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The Heart Page

George C. Roveti, MD—*Editor*

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The Acid Perfusion Test In The Differential Diagnosis of Chest Pain

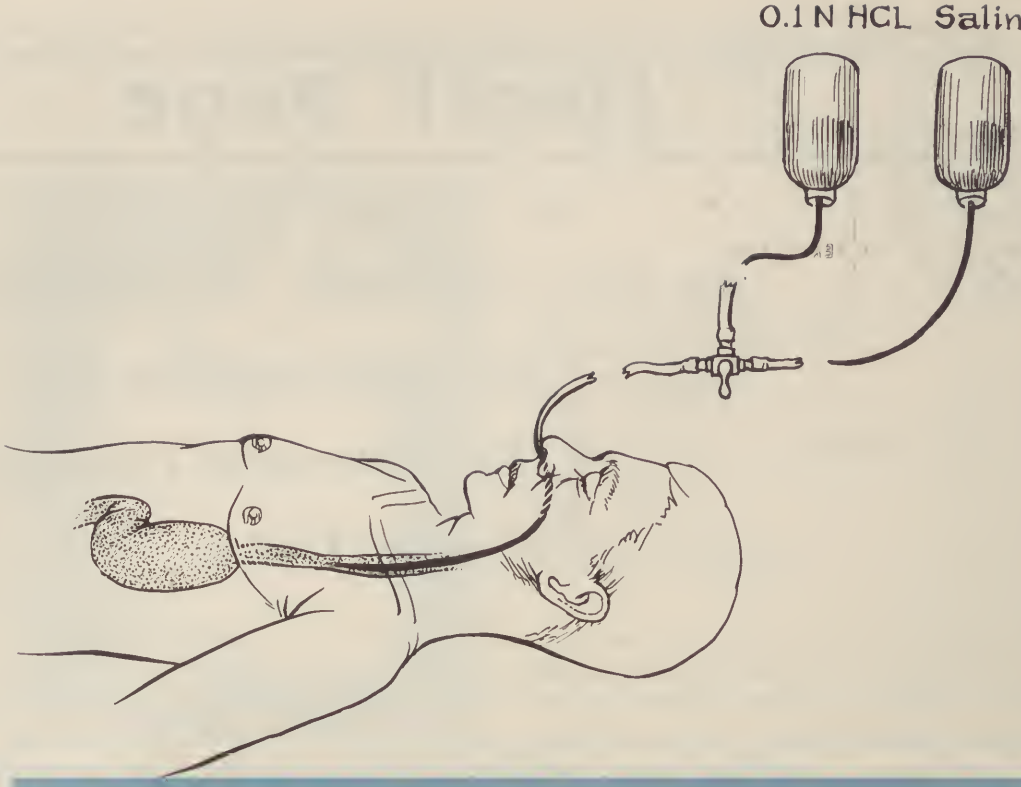
CHARLES SIEGEL, MD

The differential diagnosis of chest pain presents one of the more difficult problems of clinical medicine. Angina pectoris, reflux esophagitis, diffuse esophageal spasm, and chest wall pain syndromes, which differ so greatly in prognosis and therapy, may resemble one another in their clinical presentation. The classical patterns of these entities pose little challenge to the clinician; however, atypical presentations are sufficiently frequent to warrant the use of objective techniques as aids in differentiating these several conditions. Esophageal perfusion studies have recently gained recognition in localizing the origin of chest pain.

Symptomatic gastro-esophageal reflux, constituting the clinical entity often termed "reflux esophagitis," usually presents as burning restrosternal pain, generally aggravated by the ingestion of a heavy meal or spicy foods, and increased by lying in the recumbent position. The pain is not related to exertion and is usually relieved by the upright position or antacids. The symptoms, however, may vary considerably from this typical pattern. The pain may lateralize on the chest wall or radiate to the neck, either shoulder, or arm; it is not necessarily burning in quality. The patient may be uncertain of the relationship of symptoms to eating or exertion.

Diffuse esophageal spasm is another often baffling entity. The association of "curling" or tertiary waves in the distal one third to one half of esophagus with dysphagia or odynophagia is the classical presentation of this entity; but the pain may occur without swallowing and may be squeezing in character. Another factor which renders difficult the differentiation of this esophageal disorder from angina is the frequent effectiveness of nitroglycerine in promptly relieving the pain of diffuse esophageal spasm.

Jones[1] described the production of heartburn with perfusion of the distal esophagus with either acid or alkali. More recently, Bernstein and coworkers[2] and others have popularized this as a diagnostic technique. The technique we have employed is shown in the illustration. A No. 10 or No. 12 F nasogastric tube is passed into the stomach, then withdrawn so that the tip is 30-35 cm from the nares. By means of a three-way stopcock the tube is connected to two bottles (placed behind the patient). One bottle contains isotonic saline (plain water or glucose solution may be used if saline is contraindicated); the second bottle contains the same solution with acid added to render it 0.1 N HCl. First the saline is perfused for 10 minutes at a rate of 90-120 drops/minute. Without the patient's being aware of the change, the perfusing solution is then switched to 0.1 N HCl, with perfusion maintained at the same rate for at least 15 minutes. If the patient's spontaneously occurring symptoms are reproduced, saline is again reinstituted. Relief of symptoms generally occurs in three to five minutes.



Technique of acid perfusion. The patient is shown in the recumbent position, which permits more sustained contact of the esophageal mucosa with the perfusing solution. The acid perfusion study is most commonly performed, however, with the patient sitting.

The production of symptoms with acid but not with saline is strong evidence that symptoms originate in the esophagus. In patients with suspected ischemic heart disease, simultaneously performed serial electrocardiograms are helpful. The demonstration of esophageal motility abnormalities during the symptomatic period further incriminates the esophagus as the source of symptoms. Even without motility studies, the acid perfusion study may be performed as an office or hospital examining room procedure.

REFERENCES

1. Jones, C. M., and Richardson, W.: Observations on the nature of "heart-burn." *J Clin Invest* 2:610, 1926.
2. Bernstein, L. M., and Baker, L. A.: A clinical test for esophagitis. *Gastroenterology* 34:760, 1958.



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THE SURGICAL MANAGEMENT OF GASTROINTESTINAL HEMORRHAGE, IN PATIENTS WITH HEREDITARY HEMORRHAGIC TELANGIECTASIA will be the title of the Finney Lecture. This will be presented by **Howard A. Patterson, MD,** chief of surgery, Roosevelt Hospital; and clinical professor of surgery, Columbia University. Dr. Patterson was born in Salem, N. C., and was graduated from the University of North Carolina. His MD degree was obtained from Harvard Medical School; his postgraduate surgical training was at the Roosevelt Hospital in New York and the Peter Bent Brigham Hospital in Boston. Since 1929, he has served on the staff at Roosevelt Hospital, except for military service in World War II, during which he served as a lieutenant colonel with the Army Medical Corps in the Mediterranean and European Theatres. Dr. Patterson is a Fellow of the American Surgical Association, Southern Surgical Association, and is president-elect of the American College of Surgeons.

The Trimble Lecture will be presented by **Franklin T. Brayer, MD,** on POPULATION CONTROL: WHERE DOES THE PHYSICIAN FIT IN? Dr. Brayer is director of the Center for Population Research at Georgetown University. His graduation from the University of Rochester, School of Medicine and Dentistry, in 1944, was followed by a rotating internship and a sojourn in the US Naval Reserve. From 1946 to 1950, Dr. Brayer practiced general medicine in Rochester, N. Y. In 1950 he undertook a two-year fellowship in cancer research and radioisotopes at the University of Texas, M. D. Anderson Hospital for Cancer in Houston. This was followed by a fellowship at the University of Rochester in cancer research. Dr. Brayer then worked as a full time researcher in radiation biology at the University of Rochester, Atomic Energy Project, until 1959, when he was appointed head of the Radioisotope Unit at Georgetown Medical Center. While in this position, he became interested in the problems of the world's expanding population.



Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

CHARACTERISTICS OF ALCOHOLICS

THERE IS NO SPECIFIC, isolated personality trait inherent in the person who is to become an alcoholic. As far as we know, any person has some potential for alcoholism. It is apparent, however, that a reasonably mature person will have less likelihood of becoming an alcoholic than an immature person. An estimated 65,000,000 drinkers do not develop this disease. Once the disease has become established, several personality traits become apparent. The following characteristics may be found in persons suffering from alcoholism, with infinite variations, of course, but with sufficient consistency to warrant listing.

1. Extreme emotional immaturity. This is perhaps the most common characteristic of all alcoholics. One or more of the following areas of immaturity appear:
   Egocentricity
   Egotism
   Narcissism
   Feelings of omnipotence
   The neurosis of omnipotence is perhaps the most striking of all characteristics of the alcoholic.
2. Dependency, which is engendered by the immaturity. Severe hostility toward the source of dependency.
3. Self-justification, rationalization, and tremendous self-idealization. Low self-realization and repeated failure due to excessive drinking.
4. Low threshold to pain and a very low tolerance of pain. This is especially true of psychic or emotional pain.
5. An enormous sense of guilt and abounding remorse, both real and neurotic. The alcoholic is seldom a psychopath or amoral person.
6. Constant anxiety, tension, and resentment, especially toward next of kin.

Alcohol is a quick-acting and specific drug for relieving and for escaping from these painful situations.

Alcoholism initially involves the experimental use of alcohol, and later its compulsive and addictive use, to dissolve anxiety, reduce tension, release resentment, and solve all problems nonspecifically but only temporarily.

Other evidence suggests that alcoholics do not ever drink in the ordinary sense of social drinking. Rather, alcoholics consume large quantities of their favorite "medicine" in order to treat what ails them. Alcohol is a pain reliever; if the pain of life gets severe enough, the alcoholic will resort to his "pain remover" until the time comes when he has discovered by experience that alcohol brings more pain and discomfiture than it relieves. It is not cruelty but rather a manifestation of compassion to suffer with an alcoholic by allowing all the consequences of the drinking to take their full measure of pain. Only when the family is able to do this is an alcoholic likely to begin his recovery.

If the family does not intervene, and the disease runs its course, the alcoholic may reach a point where the pain becomes unbearable, help is sought, and recovery is effective. Merely waiting for the alcoholic to want to stop drinking while allowing the disease to call every turn in the life of the family is futile as well as cowardly. Most alcoholics *can be motivated* to seek help.

Excerpt from *Alcoholism: A Guide for the Clergy*, by the Rev. Joseph L. Kellerman, published by the National Council on Alcoholism, Inc.



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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Psychological Factors in Rehabilitation

DOUGLAS CARROLL, MD

IN PREVIOUS COLUMNS THE IMPORTANCE of beginning rehabilitation during acute illness was emphasized. The personal physician must initiate rehabilitation efforts. In considering the rehabilitation of a specific patient, the most important step is establishment of a diagnosis on which treatment and prognosis can be based. The second step is estimation of the degree of physical independence in activities of daily living. A third and crucial factor is the patient's mental and emotional resources. It is possible here only to suggest certain important concepts and give some selected references. Three psychological aspects of rehabilitation will be considered:

Chronic Brain Syndrome.—This term is applied to a *syndrome* characterized by prolonged disorientation and memory loss. It is associated with a number of different disease processes, some of which are curable. It is purely descriptive, and one should not be content to rest on his diagnostic oars in Brain Syndrome harbor.

Rehabilitation requires learning new ways of performance, so that orientation and memory are fundamental for success. Orientation as to name, place, and time may be easily established. Immediate memory may be tested by giving the patient the name of a city, a river, and a country to remember and asking for recall later. A more sophisticated test of memory is successive subtraction of seven from one hundred, which requires the patient to keep one number in mind while subtracting another from it.[1]

The Mental Status Check List[2] is a series of questions which incorporates many of the above methods. It is short and may be scored. In our experience[3] with this test over several years on several thousand patients, it gives a good indication of the patient's judgment, attention, orientation, and familiarity with his surroundings. Recently the Mental Status Check List was administered to 500 patients coming to a department of physical medicine and rehabilitation. A perfect score on the test is 50. Only one fifth of the patients with scores under 20 showed any improvement in activities of daily living over a prolonged treatment period. Nearly one half of those with scores over 20 showed improvement.

A number of patients who had very low scores on the Mental Status Check List were not suspected of having difficulty with orientation and memory by physicians who had performed exhaustive histories and physical examinations. It is our impression that many elderly people are able to cover up minor degrees of memory loss and disorientation by confabulation and avoidance of definite statements.

Motivation.—If orientation is a basic requirement for beginning rehabilitation, motivation must be present to carry the effort through to a final conclusion. Although orientation can be tested adequately by simple methods, motivation is a complex combination of many different attitudes and factors[4] The concept of motivation today is comparable to the concept of intelligence 50 years ago; that is, motivation is a popular term which is vague in concept and not susceptible to exact definition. It is a state of mind recognized and tested by behavior. It is difficult to design a test for an activity which can be defined only in general terms.

In many situations the personal physician will have an excellent grasp of the patient's back-

ground, attitudes, and past performance. Such an intimate understanding of the patient as a person is probably far superior to any type of formal testing procedure of motivation which is known today.

Psychological Reactions to Life-Threatening Diseases.—Fear and anxiety almost always accompany chronic and life threatening disease.[5] There may be fear of pain and fear of loss of independence as well as fear of death. It is how the patient reacts to his fears that will determine how disabling the psychological reactions will be.

A second important transaction is how the patient reacts to dependency or its threat. If he is too dependent he will capitalize on his illness and become demanding and imperious. If he refuses necessary dependency, he becomes angry, frustrated, and denies his illness.

Anger, guilt, and depression are other frequent accompaniments of chronic disease. Too much anger results in blaming of others, unreasonableness. Too little obvious anger results in suppression of emotion.

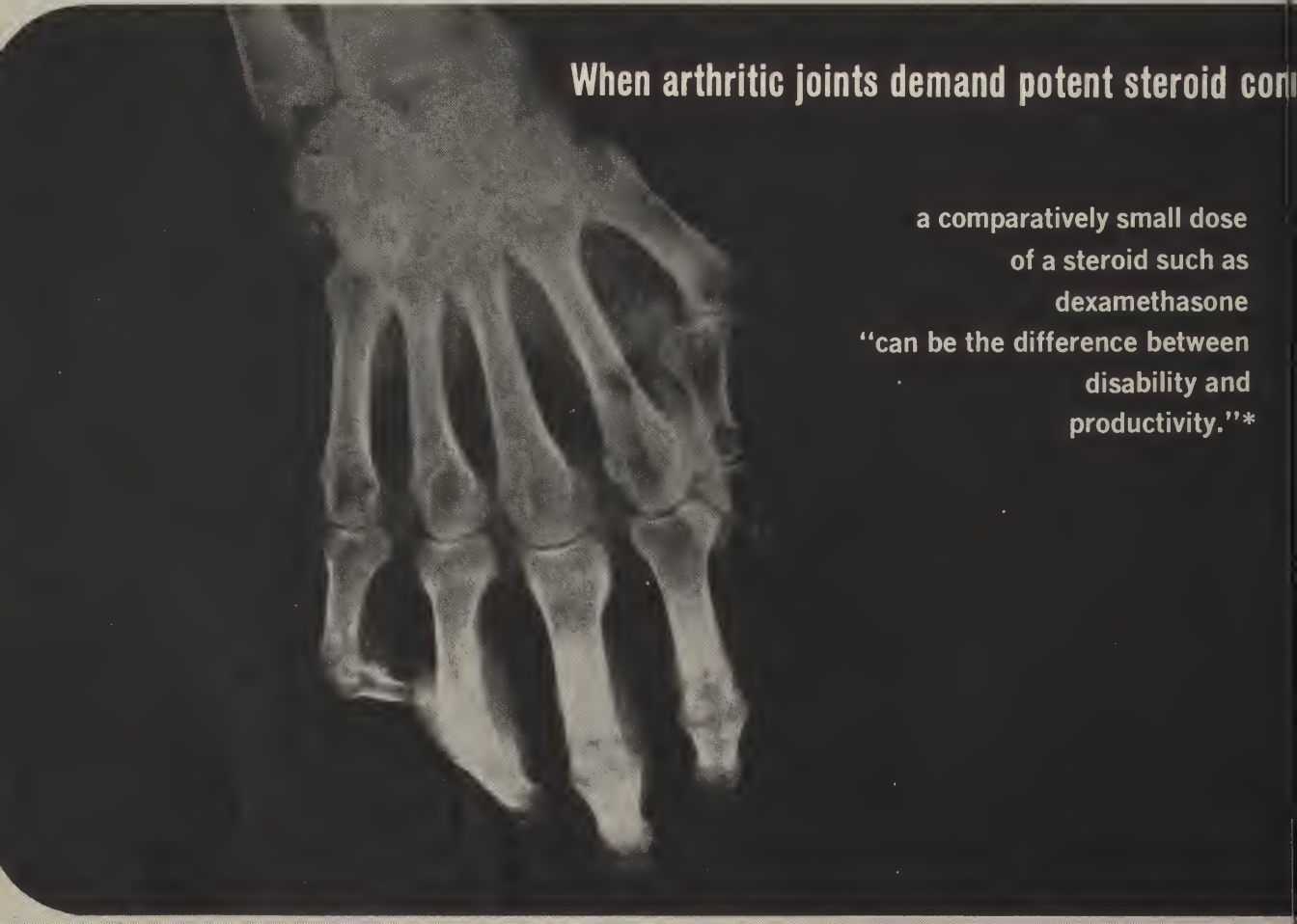
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Observation of patients who do well in rehabilitation has revealed the following behavioral patterns of successful patients:

Alertness.—Undergirding any improvement in physical function must be the ability to learn. Rehabilitation is largely a teaching exercise. Unless the patient is able to follow directions and remember what he has learned each day, it will be impossible for him to build new activities on the simple functional maneuvers taught in rehabilitation. Educational background and work habits may also be important in predicting whether the patient has the basic attention and alertness to learn.

Activity, Aggressiveness, Energy.—Probably the most important feature of the patient who reaches maximal possible independence is that of vigorous activity. Not only is he willing to work hard in the face of difficulty and discouragement but also he is active mentally with spontaneity and ingenuity to use his abilities rather than regret his disabilities. He is the opposite of the passive or depressed patient.

Realistic Goals.—To set realistic goals, the



patient must be able to recognize the extent, permanency, and liabilities of his impairment. If he underestimates his potentialities, he may tend to be passive and dependent; if he overestimates his potentialities, he may exhibit unrealistic denial of disability. The person who has enjoyed a meaningful and fruitful family or vocational experience and can see the possibility of returning to such a life seems to have the best prognosis for independence.

Cooperation.—At its lowest level, cooperation requires putting up with the hospital routine and following the advice of the doctors and paramedical personnel.

* * * * *

We know that alertness of mental functioning, aggressiveness, and energy of activity are essential for the development of motivation; but all people who have these attributes do not improve.

From time to time we see patients who seem determined to avoid taking help that really counts. Punishing or ridiculing patients in an attempt to get them to do what we want them to do is rarely successful. Improvement may seem important to us and might be a feather in our hats as physicians; nevertheless, patients have no moral obligation to fulfill our plans for them. Generally the patient's problem is not that he does not know what is good for him but that he does not know how to overcome his fear of being unable to meet the demands which improvement may bring. Under these circumstances, pushing the patient too hard may only confirm his fears that he will never be able to fulfill expectations. Acceptance and understanding may be more effective.

REFERENCES

1. Hayman, M.: Two Minute Clinical Test for Measurement of Intellectual Impairment in Psychiatric Disorders, *Arch Neurol Psychiat* 47:454, 1942.
2. Lifshitz, K.: Problems in the Quantitative Evaluation of Patients With Psychosis of the Senium, *J Psychol* 49:295, 1960.
3. Carroll, D.: Comprehensive Evaluation and Management of Inpatients With Chronic Impairments, Paul Harrod Co., Baltimore, 1962.
4. a) Shontz, F. C.: Concept of Motivation in Physical Medicine, *Arch Phys Med Rehab* 38:635, 1957. b) Eysenck, H. J.: Measurement of Motivation, *Scientific American* 208:130, 1963.
5. a) Senescu, R. A.: Development of Emotion Complications in the Patient With Cancer, *J Chron Dis* 16:813, 1963. b) Chodoff, P.: Adjustment to Disability, *J Chron Dis* 9:653, 1959.

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DOSAGE: In rheumatoid arthritis, the initial daily dosage ranges from 1.5 to 3.0 mg. The dosage is then decreased gradually to the minimum that will maintain sufficient relief; this may be as little as 0.75 mg. per day. After extended therapy, it is especially important that the drug be withdrawn gradually to allow recovery of normal adrenal function.

* Rothermich, N. O.: Postgrad. Med. 35:117, 1964.

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THE ENGLISH DISEASE

WILLIAM KEITH C. MORGAN, MD
Assistant Professor of Medicine, University of Maryland School of Medicine

SINCE THE TIME OF COLUMBUS, the French have chosen to refer to a well known infectious process as the "Italian Disease." The Italians, on the other hand, prefer to diagnose this same clinical entity as the "French Disease." One cannot but feel that this is a somewhat chauvinistic approach to the scars and ravages resulting from the embrace of Aphrodite, a goddess characterized by her munificence and singular lack of nationalistic fervor. Recently the English have laid claim to another disease and, although lacking the romantic origin of the Italian disease, chronic bronchitis has nevertheless, acquired a certain notoriety as a cause of considerable mortality and morbidity in England and to a lesser extent in the USA and Western Europe. Twenty years ago a diagnosis of chronic bronchitis was meaningless to most physicians in the United States. Now, with the more adequate dissemination of medical knowledge, this disease is described, if a trifle sparsely, in the recent editions of the standard textbooks of medicine used in this country. Formerly it was known as "smokers cough," a term which sounds so innocuous that it was not thought worthy of mention in learned texts.

Chronic bronchitis is defined as a disease characterized by the secretion of excess mucus by the bronchial tree. Pathologically, there is an increase in the number of mucous glands and goblet cells present in the bronchial wall. Clinically, it makes itself manifest by the symptoms of cough and sputum which occur in the absence of localized destructive disease such as bronchiectasis or tuberculosis. A normal person secretes 100 ml of mucus a day. This is analogous to insensible perspiration in that one is not aware of it as it is continuously swept up by ciliary action and subconsciously swallowed. By the time chronic bronchitis has developed, the subject usually has a persistent cough. This to begin with is often relatively dry, but as time goes on it eventually produces increasing amounts of mucoid sputum. The disease characteristically affects male cigarette smokers living in urban communities. In the early stages, the symptoms of cough and sputum are accepted with equanimity as the price which the smoker must pay for his pleasure. Later his attitude changes and he finds the price excessive. After 5 to 10 years of these symptoms, the patient with chronic bronchitis notices that every time he has a viral infection of his upper respiratory tract, it tends "to go to his chest." His sputum becomes mucopurulent or frankly purulent and there is a concomitant shortness of breath. He is now suffering from obstructive airway disease, and clinical signs of emphysema may be present. From now on his course is that of slow but steady deterioration until he finally succumbs to cor pulmonale or respiratory failure.

Many bronchitic subjects, on awakening, have to spend their first 30 minutes or so performing their bronchial toilet. This procedure involves either sitting on the edge of their bed or lurching to the bathroom, where they alternately hawk, spit, pant, and drag on a cigarette until they have slowly levered up from the bronchial tree some tenacious blobs of mucus or mucopus, after which they feel somewhat better. This esthetic ritual

sometimes prompts the oversensitive wife to send her bronchitic husband to seek medical advice.

Assuming the subject with chronic bronchitis seeks medical aid, what can be done to alleviate his symptoms? It seems that the excess mucus is secreted as a protective measure to counteract the chronic irritation produced by air pollution and cigarette smoking. The cessation of smoking is therefore imperative if the progress of the disease is to be arrested. Secondly, one can attempt to relieve the associated obstruction of the smaller airways. In general this is irreversible and consequently this sort of approach is not too rewarding.

As has already been mentioned, the disease is characterized by acute exacerbations in which the subjects' sputum becomes purulent, his dyspnea worse, and occasionally in the later stages of the disease cor pulmonale ensues. How these acute exacerbations are produced is still not completely clear. Culture of the sputum of subjects with chronic bronchitis most commonly yields *Hemophilus influenzae* and *Diplococcus pneumoniae,* and there is excellent circumstantial evidence that these organisms are concerned with the exacerbations.[1] Thus, *Hemophilus influenzae* and *Diplococcus pneumoniae* can be isolated more frequently from the sputum when it is purulent than when it is mucoid; furthermore, the treatment of the exacerbations with an appropriate broad spectrum antibiotic cuts short their duration and lessens the purulence of the sputum. Primary bacterial infection is not the whole story, however, for if it were, then the daily administration of a suitable antibiotic should completely avert the exacerbations. This does not happen, for although daily tetracycline throughout the winter months lessens the duration of the exacerbations and seems to prevent or reduce the severity of some of them, complete protection cannot be achieved by this means.[2] It seems, therefore, that factors other than primary bacterial infection precipitate the acute exacerbations. Carilli and co-workers studied the natural course of this disease and were able to show evidence of an antecedent viral infection preceding the exacerbations in about 50% of their subjects.[3] Thus, it seems that viral infections can damage the bronchial mucosa and allow secondary bacterial infection to occur. It would seem probable that air pollution can act in a similar fashion. The evidence to date suggests that the prompt and effective treatment of these exacerbations is as effective as are long term antibiotics. It is therefore recommended that any patient with chronic bronchitis who develops an upper respiratory tract infection with an associated increase in the purulence of his sputum should immediately be given a 7 to 10 day course of an appropriate antibiotic. In this context, one of the tetracyclines (2 gm daily) or ampicillin (3 to 4 gm daily) is to be preferred.

It can be seen that the English have no monopoly of this disease, and it is becoming an increasing problem throughout the western world. Just as casual acquaintance with Aphrodite may lead to the same stigmata, no matter whether one is French or Italian, so air pollution and cigarette smoking lead to chronic bronchitis no matter what one's nationality is. As with all diseases, prevention is better than cure; but let us do what we can for the established case, knowing full well that the only patient likely to stop smoking is the respiratory cripple.

REFERENCES

1. May, J. R.: *Lancet* 2:534, 1953.
2. Francis, R. S., and May, J. R.: *Brit Med J* 1:728, 1964.
3. Carilli, A. D. et al: *New Eng J Med* 270:123, 1964.

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Program for Retarded at Henryton State Hospital

EDGARS M. MACULANS, MD
Superintendent, Henryton State Hospital

Henryton State Hospital is an institution for the training and habilitation of ambulatory, moderately and severely retarted adults. It has 19 buildings, attractively landscaped, on 109 acres of ground in the southeastern portion of Carroll County near Sykesville.

Henryton State Hospital was opened in 1923 for the treatment of tubercular patients in Carroll County. Eventually it had a capacity of 425 beds, and they were well used. Improved detection and treatment programs, including the introduction of new drugs and modern chest surgery, virtually eliminated the need for the traditional long rest cure; and the patient population at the state tuberculosis hospitals decreased significantly.

On February 7, 1962, Governor Tawes recommended and the legislature approved the conversion of Henryton State Hospital to a facility which would provide services for mentally retarded adults. On September 28, 1962, the joint Board of Health and Mental Hygiene approved that Henryton would be considered as an individual hospital. To Henryton State Hospital has been assigned the care and treatment of adult mentally retarded persons who have developed at least to the minimal level of self-care; the toilet-trained and those able to feed and dress themselves, who have shown no outward behavior, and who have no undue physical handicaps. It was felt that in the past this congeneric group has been handled principally as custodial; custodial because there has been no plan or program to help them to develop further.

The Department of Mental Hygiene decided that Henryton State Hospital, at least temporarily, would admit mentally retarded clients by transfer from Rosewood State Hospital. In preparation for the transfer, an orientation program for the personnel of Henryton was started at Rosewood State Hospital in July, 1962. The purpose of this training program was to help the Henryton personnel make the change from bedside nursing to working with adult severely retarted patients. This included all activities connected with the training program available at Rosewood.

So that the residents and employees could become better acquainted with each other, we at Henryton began our work with mentally retarded with a day-care program in August, 1962. On October 1, 1962, the first group was admitted for residency. From that date to the present we have admitted 357 residents. Most of them are severely retarded, a smaller proportion is moderately retarded.

The residents are organized in groups of 14, each provided with a group leader who works with the group throughout the day. The daily schedule includes a work program geared toward developing and improving simple skills, made up of woodwork shop, arts and crafts, music and rhythm classes, sewing classes, recreational activities including dancing and supervised play, personal habits and motivation classes. Weather permitting, the residents spend a part of the day in outside activities, including walking.

At Henryton every activity, including meals and baths, is considered part of the overall training scheme. Each group leader keeps the resi-

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dents aware of their personal hygiene and general appearance. At meals, for instance, the leader helps his group to learn table manners and the proper use of knife and fork. Each resident makes his own bed and takes a daily bath. Residents help in the general cleaning of the buildings and grounds, all under supervision.

Facilities at the hospital include an infirmary with 11 beds for the acutely ill. An auditorium is available for religious services, movies, and dramatics. The residents also attend outside performances such as circuses and other events. Regular shopping trips are scheduled so that residents may purchase necessary items of their own choice. Picnics both on the hospital grounds and outside are held. Sight-seeing trips to significant places in our state are also planned. Every hour of the day is planned with some kind of activity directed toward providing a stimulating environment and promoting socially acceptable behavior through a regular schedule of constructive and purposeful activities. We believe that the residents should preserve contact with their families and the community so that their social growth may be furthered. In most cases the institution should proceed with the assumption that they are, if possible, to be made ready sooner or later for community life. We have placed 22 residents into foster home care.

An out-patient day care program has been initiated at Henryton for the mentally retarded adults of the surrounding counties. From 9 AM to 4 PM they are enrolled in the routine training rehabilitative program by joining in the different activities scheduled for residents of the hospital. The first participants are from Howard County.

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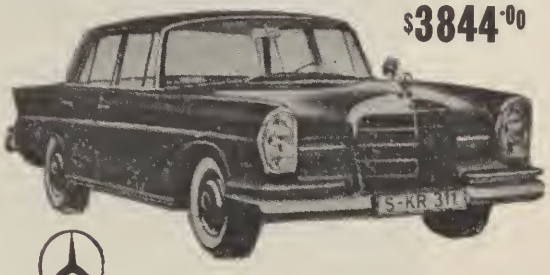
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New Maternity and Infant Center Is Open

PHYSICIANS ARE ADVISED that the City Health Department's new Baltimore Maternity and Infant Center is now open for patients at 211 West Lombard Street, in the Baltimore and Ohio Annex Building across from the Civic Center. The new facility incorporates the City Health Department's Maternity Interviewing Service, formerly at 414 N Calvert Street, and provides many additional services for needy prenatal patients.

A complete obstetrical evaluation is available to the patient at the initial visit. Plans for subsequent care is based on the specific needs of the patients as indicated by the medical and dental examinations and interview with patient. The major objective is to find the patients who are more vulnerable to perinatal hazards and provide comprehensive care.

The new center will:

1. Help patients plan for prenatal and postnatal care including arrangements for delivery.

2. Coordinate services to patients with health, including nutrition, and social problems. District health centers are alerted to the need for public health nursing home visits.

3. Include a dental facility to insure comprehensive dental care as needed.

4. Arrange for follow-up for "high risk" infants, such as premature babies, those with blood incompatibility, brain damage, genetic defects, metabolic disorders, and other conditions which are a threat to life.

With these services now available, physicians may refer their medically indigent patients to the center for registration and care. These referrals will aid the City Health Department in its continuing efforts to reduce the high rates of infant mortality, prematurity, mental retardation, and other morbidity.

The new Maternity and Infant Care Project (Project 501) is under the direction of John J. Bianco, MD,MPH. He is assisted by a staff of 35, comprising obstetricians, pediatricians, dentists, public health nurses, social workers, nutritionists, interviewers, a health educator, a laboratory aide, and a secretarial staff. The program is under the administrative supervision of J. L. Rhyne, MD, director of Child Health Services, and George H. Davis, MD, associate director in charge of maternity hygiene. Dr. Bianco will welcome any calls from physicians to discuss maternity and infant care problems. His telephone is 752-7282.

COORDINATOR OF ALCOHOLISM PROGRAMS APPOINTED

Harry E. Shelley has been appointed coordinator of alcoholism programs for Baltimore City, a new post in the Baltimore City Health Department recommended by Mayor McKeldin's Committee on Implementation of Alcoholic Programs. Mr. Shelley will coordinate and promote treatment and rehabilitation programs for persons with problems of alcoholism. More specifically,

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he will provide liaison and close cooperation between the City Health Department and public and voluntary agencies interested in alcoholism. The work of the new coordinator will also involve the initiation and development of educational programs in the field of alcoholism for both professional persons and the public.

Mr. Shelley comes to the Health Department eminently qualified for this work. For the past 10 years he has been associated with the Church of the Guardian Angel, in Baltimore, first as curate and later as rector. During most of this time he has been actively engaged in the field of alcoholism. He has been president of the board of directors of Valley House, a halfway home for the rehabilitation of alcoholics sponsored by the Episcopal Diocese of Maryland; a member of Mayor Grady's Committee on Alcoholism; a member of the City Health Department's Advisory Board to the Department's alcoholism clinics in the Eastern Health District Building; chairman of the Subcommittee on Alcoholism and Alcohol Studies of the Department of Christian Action of the Diocese of Maryland, and sponsor of the Guardian Group AA, which meets at the Church of the Guardian Angel. As rector of the church he has counseled many alcoholics and their families.

A native Baltimorean, Mr. Shelley received his early education in the Baltimore area. He was a pharmacist mate in the U.S. Navy during World War II and participated in the invasions of Normandy, the Philippines, and Okinawa. After his discharge, Mr. Shelley attended the University of Baltimore. He received his LL B in 1950 and was admitted to the bar the same year. Turning to the ministry, he attended the Philadelphia Divinity School and received the Bachelor of Theology degree in 1955.

Mr. Shelley's office is in the American Building, Baltimore and South Streets, where the central administrative offices of the City Health Department are located. Physicians are invited to discuss with Mr. Shelley any problems related to the alcoholic. His telephone number is 752-2000, extension 842.

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Highlights

NEW COMMISSIONER APPOINTED

WILLIAM J. PEEPLES, MD, Maryland's new health commissioner, has had an extensive public health career. He returns to Maryland from a position as chief of the Bureau of Chronic Diseases, California State Department of Public Health. He was health officer in Montgomery County, Maryland, from 1955 until 1963. In his nearly 20 years of public health service, he was health officer of Troup County, Georgia, and Monroe County, Florida, and assistant health officer of Muscogee County, Georgia.

During his years in Maryland, Dr. Peeples lectured in public health at the Johns Hopkins School of Hygiene and the Georgetown University Medical School and was an instructor in public health administration at the Catholic University.

Dr. Peeples is a Fellow of the American Public Health Association, a trustee of the American Association of Public Health Physicians, secretary-treasurer of the Association of State and Territorial Chronic Disease Directors, and a member of the American Medical Association. He received his MD from the Medical College of Georgia and was awarded a master's degree in public health from the University of North Carolina.

During World War II, Dr. Peeples served in the U.S. Army. He holds a reserve commission as colonel in the Army Medical Corps.

MEDICAL CARE PHYSICIANS' SERVICES

The Physicians' Services Committee of the Council on Medical Care met with the Executive Committee of the Medical and Chirurgical Faculty on December 17 to discuss physicians' services in the Medical Care Program. It was decided that better communication between the field and the Physicians' Services Committee was essential. The Executive Committee will recommend to the Council that physicians be appointed to act as a liaison between the Medical Care Council and the local component societies and their members.

OCCUPATIONAL THERAPY ASSISTANTS PROGRAM

Fourteen students have enrolled in the revised 20-week course of the Maryland Program for Occupational Therapy Assistants. Their instruction, unlike that of any of the other 11 approved courses in the United States, will qualify them to work in geriatrics, pediatrics, psychiatry, and general medicine. Previous Maryland graduates received 12 weeks of instruction preparatory to qualification only in general medicine.

GUTHRIE TEST AVAILABLE TO ALL MARYLAND HOSPITALS

Hospital officials have been notified that the Guthrie test screening program for detection of PKU, which began here as a pilot program, is now available *free of charge* to all Maryland general hospitals with maternity and newborn services. The extension of the program through the Bureau of Laboratories and the Division of Community Services for the Mentally Retarded is made possible by federal funds granted to states for the improvement of maternal and child health services.

ADDITIONAL PERSONNEL FOR PREVENTIVE PROGRAMS

A staff member in the Division of Nutrition Services, devoting full time to the nutritional problems associated with mental retardation, is

thought to be the first in the country so employed. She will direct the field trial phase of the joint research project being conducted by the Department and the University of Maryland College of Home Economics to develop menu items for older PKU children. Also, she will work with the directors of day care centers for the retarded and with families and practicing physicians.

A full time medical social consultant and a speech and hearing consultant in the Division for Crippled Children will add greatly to the services provided to handicapped children.

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A MIDYEAR REPORT

First Six Months Of Fiscal Year	Average Size of Hospital Population	Total Patients Treated	Admissions	Discharges
1962	8,297	14,236	2,877	2,443
1965	8,005	15,406	4,084	3,170
Net change	—292	+1,170	+1,207	+727
Per cent change	—3.5	+8.2	+42.0	+29.8

A total of 15,406 patients were treated in Maryland's psychiatric hospitals during the first six months of the current 1965 fiscal year. The increase of 1,170, or 8.2%, during the past three years represents a continuation of a long range upward trend.

This steady growth has been due mainly to the rapid patient turnover resulting from the growing number of admissions for short term treatment of acute disturbances. As indicated in the table, both admissions and discharges increased substantially between 1962 and 1965. At the same time, the average size of the hospital population decreased more than 1% annually.

Most new patients are now released after a short period of hospitalization, and almost all leave within one year. This has meant that there is but a small buildup of new chronic cases. As former long term patients die or are released, they are no longer replaced by new chronic cases. The net effect of this has been that:

1. The proportion of beds occupied by chronic long term patients is decreasing while the proportion occupied by acute short term patients is rising.
2. The average length of hospitalization of newly admitted patients is going down.
3. The average size of the hospital population is gradually declining at the same time that the total number of patients treated is increasing.

These factors have important implications. It should be clear that patient-staff ratios applicable to a custodial hospital population are not applicable to a patient population experiencing a rapid turnover. Continuing re-evaluation and reassessment of needs are therefore indicated if adequate service levels are to be maintained.

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Louis Krause, MD, Chairman
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Visit the Library Exhibit at the Annual Meeting

With the 1965 annual meeting soon to be held, we extend a cordial invitation to all members of the Medical and Chirurgical Faculty to visit the library exhibit, get acquainted with your librarians, browse among the new books, and review the services available to you through the library.

There will be a collection of books for circulation as well as display at the exhibit, and both journal materials and books may be reserved by mailing your request to the library before the meeting.

Believing that the essence of good reference service for scientific and technical libraries is based on thorough literature searching, our library staff has endeavored to accomplish as much as staff hours allow for bibliographic services to members requesting subject bibliographies. However, we must limit this type of service to members only. Other individuals and libraries are welcome to use our indexes, abstracts, and other reference tools in the library, but our personnel is much too limited to offer them similar services.

Some of the subject bibliographies compiled during 1964 were:

Abscess in a non-lactating breast
Adolescence—growth and development
Aspirin—its uses and disuses
Autism
Bladder neck obstruction in children
Cryptococcosis
Glaucoma in the aged
Granulomas of the mediastinum
Heart failure in cirrhosis of liver
Hernia—hiatus or diaphragmatic
Hip prosthesis
Lymphangioma in children
Myelofibrosis
Pallidectomy in the treatment of Parkinson's disease
Plasma substitutes for use in mass casualties
Porphyrias
Senear-Usher syndrome or Pemphigus Erythematodes
Socialized medicine throughout the world
Spondylolisthesis
Staphylococcus Coagulase
Tracheocervical reconstruction replacement or repair
Torsion of the normal ovary and tube

RECENT ADDITIONS

American Medical Association: *Style book and editorial manual.* AMA, 1965.
American Medical Association: *Medical and surgical motion pictures.* AMA, 1964.
Cleckley, Hervey Milton: *The mask of sanity.* Mosby, 1964.
Flint, Thomas: *Emergency treatment and management,* 3d ed. Saunders, 1964.
Goldblith, Samuel A.: *Milestones in nutrition.* AVI Pub Co, 1964.
Physicians' desk reference to pharmaceutical specialties and biologicals. Medical Economics, Inc, 1965.
US Communicable Disease Center, Atlanta: *Management of chancroid, granuloma inguinale, lymphogranuloma venereum in general practice.* US Govt Print Off, 1964.
US Congress. House Committee on Ways and Means: *Health services for the aged under the social security insurance system.* US Govt Print Off, 1961.
US Congress. House Committee on Ways and Means: *Medical care for the aged.* US Govt Print Off, 1964.
US Congress. House Committee on Ways and Means: *Social security legislation.* US Govt Print Off, 1958.
US National Institutes of Health: *Scientific directory and annual bibliography.* NIH, 1963.
Welch, Claude: *Polypoid lesions of the gastrointestinal tract.* Saunders, 1964.
Welch Medical Library: Serial holdings. 1965.

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Addenda to Directory of Registered Physicians.

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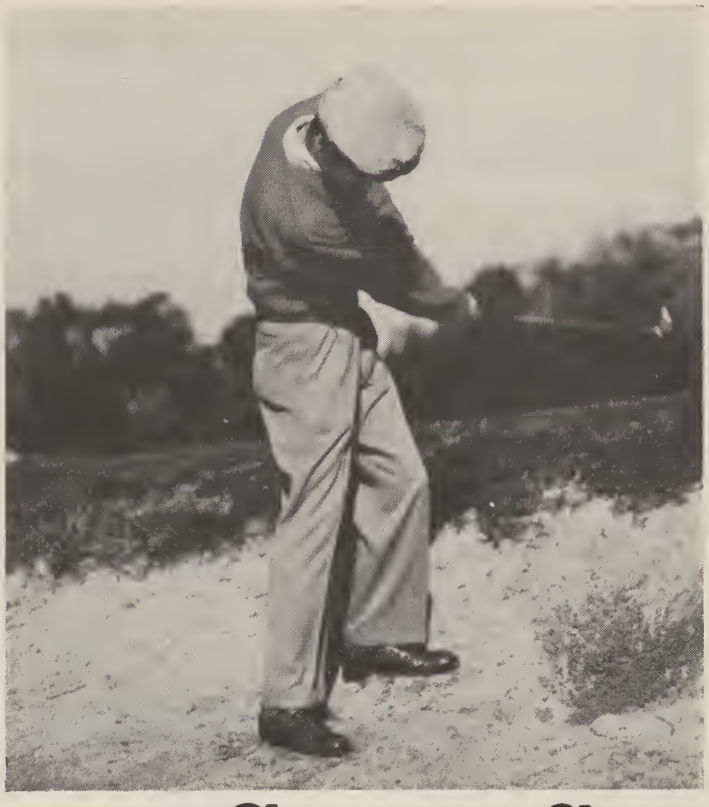
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Woods, Alexander H., V. A. Hospital, Tucson, Ariz. 85713
Woods, Robert W., Jr., 2 Victory Rd., Suffern, N. Y. 10901
Woodward, Celeste L., 1 Merrymount Rd., Baltimore, Md. 21210
Woodward, Doris Jane, Rt. #1, Box 28, Middleburgh, Va. 22117
Wooldridge, William N., 3115 N St., N.W., Washington, D. C. 20007
Worrell, Churchill Freman, 50 Highland Pl., Peru, Ind. 46970
Wright, Frederick William, 316 Potomac Ave., Hanover, Pa.
Wright, Walter Alan, 1 Stonebridge Rd., Montclair, N. J.
Wuerschmidt, Marcus A., City Savings Bank, Oswego, N. Y.
Wulwick, Michael, 434 East 23rd St., Brooklyn, N. Y. 11226
Wurzel, Milton, 2 Farley Ave., Newark 8, N. J.
Wustrow, H. Juergen, 1209 14th Ave., Altoona, Pa. 16601
Wyatt, Claire Jackson, 5 Professional Ct., Rome, Ga. 30161
Wybranowski, Jan, 17640 W. Warren, Detroit, Mich. 48228
Yanagisawa, Kazuo, 216 E. 50th St., New York, N. Y. 10022
Yao, William H., 13852 San Pablo Ave., San Pablo, Calif.
Yarbrough, Oscar Demelle, P.O. Box 457, Centreville, Va. 22020
Yashar, John J., 199 Angell St., Providence, R. I.
Yeager, Henry, Jr., 3924 Glenwick, Dallas, Texas 75205
Yessler, Paul George, P.O. Box 177, Officer's Mail Section, Fitz-Simons General Hospital, Denver, Colo. 80240
Yih, Wah Michael, 21100 Southgate Park Blvd., Maple Hghts., Ohio 44137
Yorkoff, Eugene James, 206 Black Hawk Dr., S.E., Forest Hghts., Md. 20021
Youmans, John B., Rt. 3, Franklin, Tenn.
Young, Alexander William, Jr., 420 East 64th St., New York, N. Y. 10021
Young, Joseph Marvin, Laboratory Service, V. A. Hospital, Memphis, Tenn. 38115
Young, Robert W., 1225 S. Orange Ave., Orlando, Fla.
Young, Virginia Elizabeth, 663 Coventry Rd., Berkeley, Calif. 94707
Young, William, 202 Warwick Rd., Lawnside, N. J.
Youngs, Luther Archibald, III, 4309 Havard St., Silver Spring, Md.
Yuen, Yue Lucille, V. A. Center, Temple, Tex.
Yurko, Leonard E., 3441 West St., Weirton, W. Va. 26063
Zack, Frank Anthony, 2904 Avenida Nevada, N.E., Alburquerque, N. M.
Zappala, Anthony, 6618 Kennedy Dr., Chevy Chase, Md. 20015
Zavitzianos, George, 22 Cypress St., Tenafly, N. J. 07670
Zeitlin, Simon Peter, 6500 S. Flores, San Antonio, Tex. 78214
Zerne, Gustave E., 311 Dean St., W. Chester, Pa.
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Zikria, Bashir A., 340 E. 34th St., New York, N. Y. 10016
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Woman's Auxiliary to the Maryland State Medical Society

MARCH, 1965

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Message from the President



FOR BETTER HEALTH—Better World, Speak up Auxiliary Members! So said Mrs. William H. Evans, president of the Woman's Auxiliary to the AMA. This has been the theme of our year's program, and all the auxiliaries have been busy carrying it out in many ways. Each active auxiliary member is to be commended for her generous contribution to humanity.

Our husbands devote their lives to serving humanity. It is our privilege to augment their service with our programs and thereby enrich our own lives.

Baltimore County Auxiliary's project of organizing an auxiliary for the Mt. Wilson Hospital is an example of how doctors' wives may take leadership in their community to provide services



Mrs. William H. Evans, of Youngstown, Ohio, was installed as president of the Woman's Auxiliary to the American Medical Association at the 41st annual convention in June, 1964, in San Francisco. An auxiliary member for 20 years, Mrs. Evans has served her county and state auxiliaries in many capacities. She was president of the Ohio State Auxiliary in 1956-57. On the national level, she served on the resolutions committee in 1957, as regional vice president, 1957-58, as director for two years, 1958-60, and as constitutional secretary for two years, 1961-63.

Before her marriage in 1942 to Dr. Evans, an ophthalmologist and otolaryngologist, Dena Evans was employed as an office manager, buyer, and jewelry designer. She studied at Case School of Applied Science, University of California, and the American Gemological Institute. She has retained her interest in gemology and in 1955 designed the first pin for past presidents for the Ohio auxiliary and later another pin to be used by the past presidents of all county auxiliaries in her state.

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that no other group provides. Our AMA-ERF fund-raising activities demonstrate the generosity of doctors and their families and their keen awareness of the needs of others. Knitting bandages for lepers, collecting medical supplies to send to foreign nations, and supporting other international health activities are more ways in which our auxiliary members are "speaking up."

The auxiliary board meeting in Annapolis was a self-educational activity in which we toured the State House, sat in on a meeting of the House Judiciary Committee, enjoyed an excellent commentary on the functions of the state legislature by Delegate Thomas Hunter Lowe, heard a special request for assistance from the Maryland Traffic Safety Commission by its director, Paul Burke, and attended a session of the state legislature.

To cite an example of what one member can do in service to humanity, I'd like to mention just a few of the activities engaged in by Mrs. Samuel R. Wells. Ginny has been doing a monumental job as editor of *Hygeia Filiae,* bringing the more personal aspects of auxiliary work to every doctor's wife in Maryland. She is president of her county auxiliary, and everyone knows the many facets of responsibility in this job. As if these weren't enough to bend the back of anyone, she carries on a full time job as coordinator of volunteers at the Mr. Wilson State Hospital. Surely if one person can do all this and still smile, as Ginny does, then it behooves the rest of us to make a little more effort to do our part in this world.

To those of you who may not be a member of our Woman's Auxiliary, I sincerely invite you to join us. Our programs are of such variety that there surely must be something to spark your interest. Even if this doesn't affect you, we really do wish to meet you and ask you to offer yourself to our auxiliary. May we hear from you soon?

Arlene E. Baybutt

DON'T FORGET THE ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY—
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Book Reviews

CASE STUDIES IN OBSTETRICS AND GYNECOLOGY. F. Jackson Stoddard, MD. Philadelphia: W. B. Saunders Company, 1964. $8.50

Sixty case studies are presented to illustrate many of the important problems encountered in gynecologic and obstetric practice. Most of the cases were chosen from the author's practice. Each is accompanied by a discussion of differential diagnosis and reasons for selection of treatment. Questions which the physician is likely to ask a consultant or a student to ask the teacher are phrased and answered in the manner which the author feels best covers the subject.

GASTROENTEROLOGY, vol. II, ed. 2. Henry L. Bockus, MD. Philadelphia: W. B. Saunders Co., 1964. $28

As with volume I of this work, the new edition has entailed considerable rewriting. Much newer knowledge has been contributed. Among the additions is a separate section on "Disorders of Absorption and Nutrition, and Anemias in Gastrointestinal Disorders." Part of a three-volume work, Volume II covers the small intestine, absorption and nutrition, the colon, peritoneum, mesentery, and omentum.

MARRIAGE COUNSELING IN MEDICAL PRACTICE. A symposium edited by Ethel M. Nash, MA; Lucie Jessner, MD; D. Wilfred Abse, MD, Chapel Hill, N. C.: The University of North Carolina Press, 1964. $8

Many complaints encountered in medical practice have their roots in marital difficulty. The physician should be able to recognize this as a source of somatic and psychic ills and counsel the marriage partners in achieving a satisfactory solution. The usual medical school courses and house officer training programs do not adequately prepare the physician for this aspect of his medical practice. This book, arising from two symposia on medical aspects of marriage counseling, is an effort to approach the subject from the viewpoint of the practicing physician. Various aspects of the problem are presented by individual contributors.

PHYSICAL EXAMINATION OF THE SURGICAL PATIENT, ed. 3. J. Englebert Dunphy, MD, Thomas W. Botsford, MD. Philadelphia: W. B. Saunders Co., 1964. $8.50.

This is a how-to book: how to examine the patient in order to get the most information by the simplest means. While the authors focus mainly on technique, they have included enough discussion about the disease process to make the physical signs more meaningful.

Added to this edition are new chapters on Cardiac Surgery and Burns and a special section on Emergency Resuscitation.



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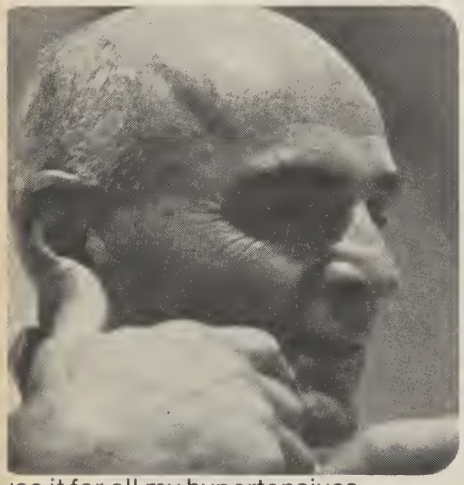
es, sir. She's down to 140/85.



Right. When we started, she was 195/120.



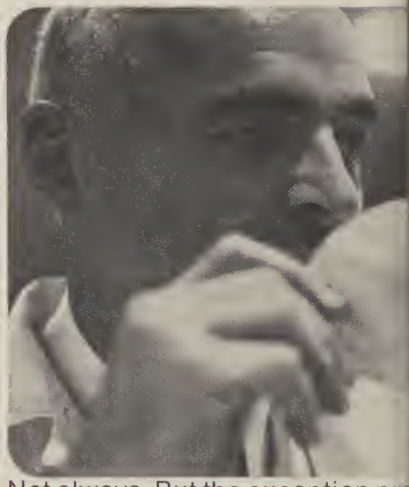
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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone p reserpine in moderately severe and severe hy tension: A two year study. Presented at the 7 Inter-American Congress of Cardiology, Mon June 14–19, 1964.

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As with the previous editions, this book should guide the student in acquiring astuteness and thoroughness in diagnosing surgical disorders and refresh the practicing physician in the appraisal of surgical lesions.

CHRISTOPHER'S TEXTBOOK OF SURGERY, ed. 8. Edited by Loyal Davis, MD. Philadelphia: W. B. Saunders Co., 1964. $18.50.

"Surgery is the dynamic, living and growing art of the application of basic science to the treatment of sick people." This is demonstrated in a new chapter, Horizons in Surgery, only one of many additions and changes in this edition.

Directed to the undergraduate student, this text emphasizes basic themes in every area of surgery.

TEXTBOOK OF PEDIATRICS, ed 8. Edited by Waldo E. Nelson, MD. Philadelphia: W. B. Saunders Company, 1964. $18

While the basic goals of pediatrics have not changed, significant changes have occurred in pediatric practice. At four or five year intervals, revisions are necessary to incorporate, evaluate, and interpret new knowledge. This edition continues to reflect a portrayal and interpretation of current pediatric knowledge and practice.

pH AND DISSOCIATION, ed. 2. Halvor N. Christensen, PhD. Philadelphia: W. B. Saunders, 1964. $2.25

This is a programmed learning text for students of the biological and medical sciences. The first edition appeared only a year ago, but the great number of comments, suggestions, and criticisms have inspired the author to revise the text to be of greater value. A number of superfluous requests and responses have been eliminated. In this revision, the concept of the pK' is introduced at once, and several sections have been added.

SYNOPSIS OF PATHOLOGY, ed. 6. W. A. D. Anderson, MD. St. Louis: The C. V. Mosby Co., 1964. $9.75

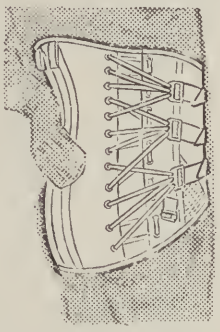
Carrying on the tradition of previous editions, this volume attempts to present pathology in a compact, concise, comprehensive form. It is intended for students and others in medical and paramedical fields who need knowledge of disease processes.

DYNAMIC PATHOLOGY. STRUCTURAL AND FUNCTIONAL MECHANISMS. Maurice M. Black, MD, and Bernard M. Wagner, MD. St. Louis: The C. V. Mosby Co., 1964. $8

This book was written to emphasize the thread of continuity which runs throughout medicine in general and pathology in particular. The authors have set for themselves a twofold responsibility: to impart the vocabulary of disease and to integrate and make meaningful that which has gone before as a basis for that which is to come. Pathology should be presented as an extension of normal structure and function.

The subject is presented here not as a hurdle in the medical curriculum but as the foundation of medical investigation and practice. While not a substitute for a formal course in pathology, this book is intended to aid both students and physicians in becoming more knowledgeable and more receptive to what is to be seen in the laboratory and the clinic.

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OCULAR AND ADNEXAL TUMORS; NEW AND CONTROVERSIAL ASPECTS. Edited by Milton Boniuk, MD. Saint Louis: The C. V. Mosby Co., 1964. $25.

An International Symposium on Ocular Tumors was held in conjunction with the dedication of the Institute of Ophthalmology of the Texas Medical Center. This book is the product of this symposium. It contains the most recent information and controversial aspects of the incidence, clinical and pathological diagnosis, and management of ocular and adnexal neoplasms.

CORNEAL CONTACT LENSES. Edited by Louis J. Girard, MD. St. Louis: The C. V. Mosby Co., 1964. $19.75

Ophthalmologists have the ultimate responsibility for the patient requiring contact lenses. For this reason, corneal contact lenses should be fitted with the ophthalmologist either making all the modifications to the lens himself or supervising the work of a technician. In either event, the ophthalmologist must know how to do the modifications himself. This book is written from the viewpoint of the ophthalmologist's performing all of the steps in the fitting. One chapter, however, is devoted to the relationship between the ophthalmologist and the technician, and suggestions are made for proper cooperation between them to assure greater protection for the patient.

EMERGENCY TREATMENT AND MANAGEMENT, ed 3. Thos. Flint, Jr., MD. Philadelphia: W. B. Saunders Company, 1964. $8.75

When an emergency occurs, the physician does not have time for a leisurely trip to the library or to study lengthy dissertations on emergency treatment. This book, of a handy size to be carried in the medical bag or the glove compartment, contains information that is contemporary, comprehensive, concise, and clear.

This edition incorporates newer methods of emergency treatment. In addition, the subject matter has been rearranged to group related conditions together as much as possible. The cross-reference system has been simplified to expedite locating a specific subject.

MASSAGE: PRINCIPLES AND TECHNIQUES. Gertrude Beard, RN, RPT, and Elizabeth C. Wood, AM, MS, RPT. Philadelphia: W. B. Saunders Company, 1964. $6

This book is both a manual for physical therapy students who are learning massage and a source of useful information for practicing physical therapists, physicians, nurses, and physical educators. Amply illustrated, it presents a clear picture of the techniques and the principles upon which they are based.

THE VISUAL FIELDS: A TEXTBOOK AND ATLAS OF CLINICAL PERIMETRY, ed 2, by David O. Harrington, MD, Mosby, 1964. $16

This is a comprehensive text on perimetry designed to serve as a clinical guide to the examination and interpretation of the visual fields. It is based on the author's own experiences, and the methods and instruments he describes are those which he has found satisfactory. In this edition, more attention has been given to the quantitative analysis of certain types of field deficit; new perimetric techniques and modifications of old techniques are described; a discussion of pediatric perimetry has been added; and the portion on the perimetry of glaucoma has been largely rewritten. New reports and illustrations are used.

PEDIATRIC PROCEDURES, by Walter T. Hughes, Jr., MD, Saunders, 1964. $7.50

An illustrated manual of generally accepted techniques common in pediatric practice, this book is directed mainly to the intern or resident training in pediatrics. Each technique is described in concise, orderly fashion, detailing equipment needed, method of performing procedure, common sources of error, and hazards and complications.

CLINICAL NEUROLOGY, by Frank A. Elliott, MD, Saunders, 1964. $12

Intended for students and residents, this book contains accounts of both common and uncommon neurological diseases and principles and practice involved in neurological diagnosis. Anatomic and physiologic considerations are stressed. Diagnostic significance of symptoms and signs are spelled out, and the value of clinical methods is emphasized.

REPRINTS ON BIRTH DEFECTS

The National Foundation-March of Dimes announces a new Birth Defects Reprint Series. The reprints are of articles which have appeared in scientific and medical literature published in the United States and abroad. The first group of reprints is ready for distribution and includes the following:

Allan C. Barnes, MD: "Prevention of Congenital Anomalies from the Point of View of the Obstetrician," from the Proceedings of the Second International Conference on Congenital Malformations, July 1963. PE-RS 1

Leslie C. Dunn, ScD: "Old and New in Genetics," from *Bulletin of The New York Academy of Medicine,* May 1964. PE-RS 2

James L. German, MD: "The Pattern of DNA Synthesis in the Chromosomes of Human Blood Cells," from *Journal of Cell Biology,* January 1964. PE-RS 3

Kurt Hirschhorn, MD: "Recent Advances in Methodology of Human Genetics," from *Bulletin of The New York Academy of Medicine,* May 1964. PE-RS 4

Henry N. Kirkman, MD: "Genetic Control of Human Enzymes," from *Pediatric Clinics of North America,* May 1963. PE-RS 5

Norman Kretchmer, MD: "Whither Birth Defects," from *Perspectives in Biology and Medicine,* Autumn 1964. PE-RS 6

R. James McKay, Jr., MD, and Jerold F. Lucey, MD: "Neonatology," from *New England Journal of Medicine,* June 4 and 11, 1964. PE-RS 7

Severo Ochoa, MD: "The Chemical Basis of Heredity —The Genetic Code," from *Bulletin of The New York Academy of Medicine,* May 1964. PE-RS 8

Joseph P. Rossi, MD: "High Risk Babies: Determining the Problem," from *Connecticut Health Bulletin,* November 1964. PE-RS 9

Edward L. Tatum, PhD: "Medicine and Molecular Genetics," from *Bulletin of The New York Academy of Medicine,* May 1964. PE-RS 10

These may be ordered from Medical Department, The National Foundation-March of Dimes, 800 Second Avenue, New York, N. Y. 10017.



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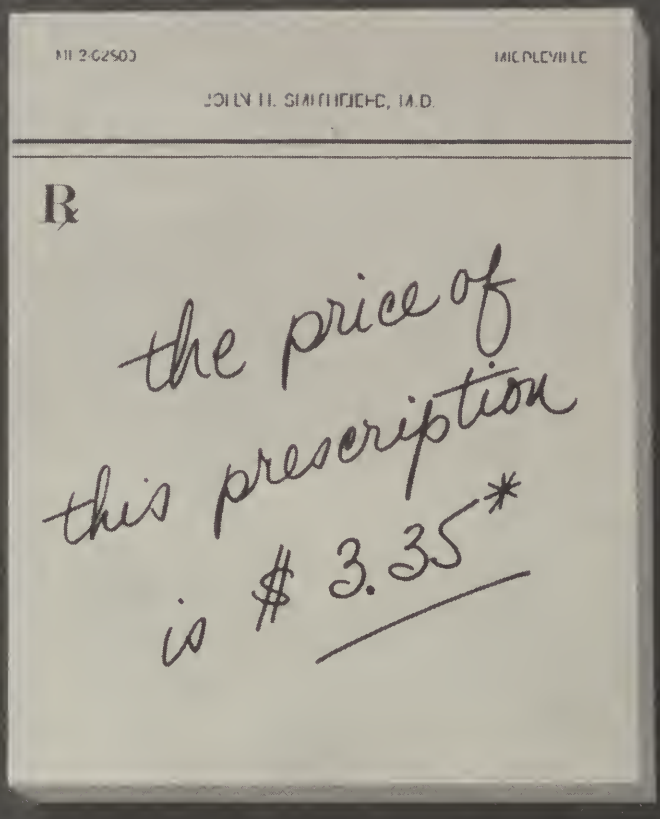
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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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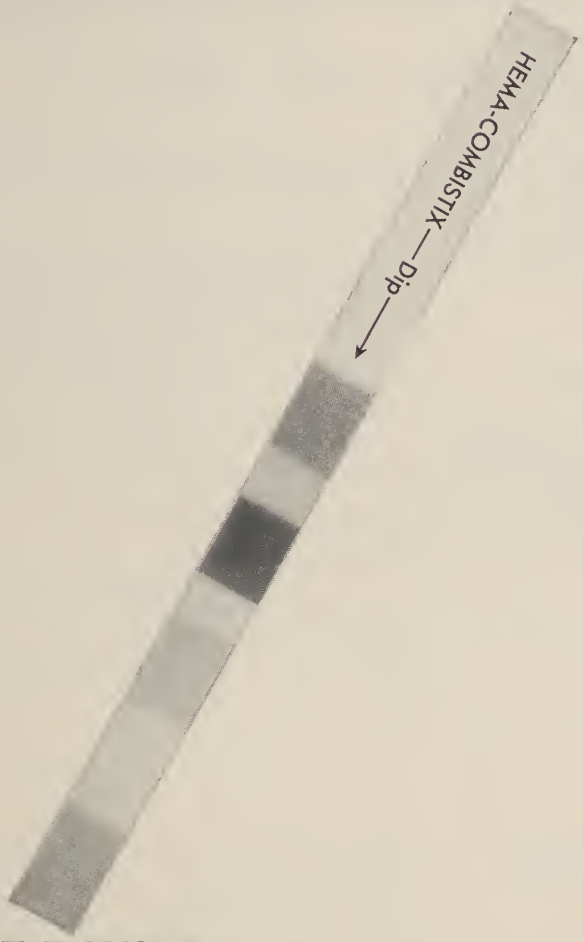
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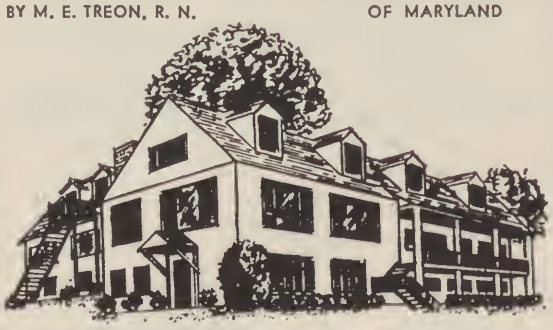


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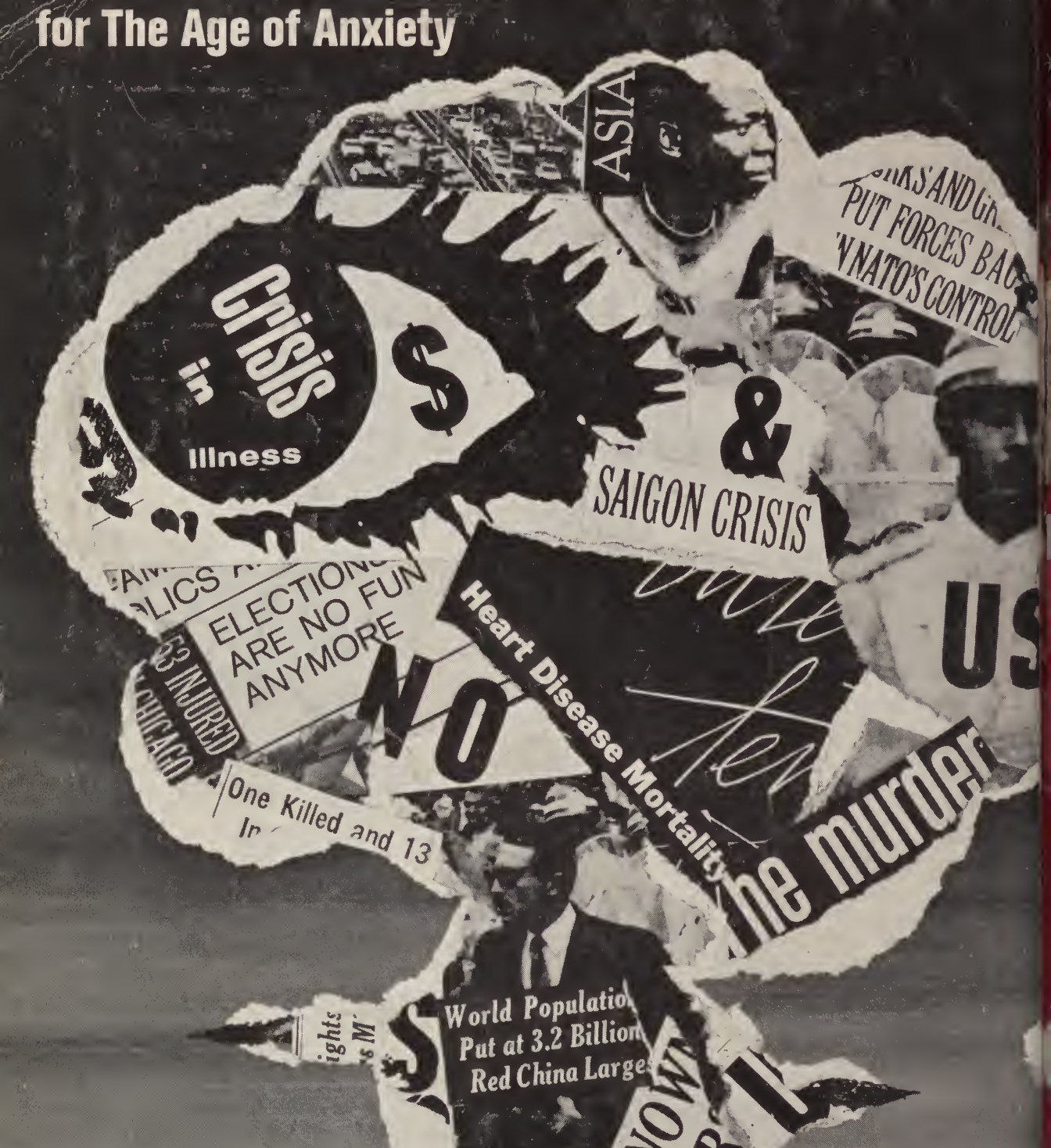
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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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April 21-23—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland.

June 20-24—Annual convention, American Medical Association, New York City. See *JAMA* May 10 for complete scientific program and registration forms.

SINAI MEDICAL STAFF

April 22—8:30 PM—Zamaiski Auditorium, Sinai Hospital, Baltimore
"Clinical Uses of Hyperbaric Oxygen Therapy," C. R. Stephen, MD, professor of anesthesia, Department of Surgery, Division of Anesthesia, Duke University Medical Center.

CONGRESS ON ENVIRONMENTAL HEALTH PROBLEMS

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Sponsored by AMA Committee on Environmental and Public Health. Theme: "Population, Environment, and Health." Write to Department of Environmental Health, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

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BCMS COMMITTEE ON MEDICINE AND RELIGION

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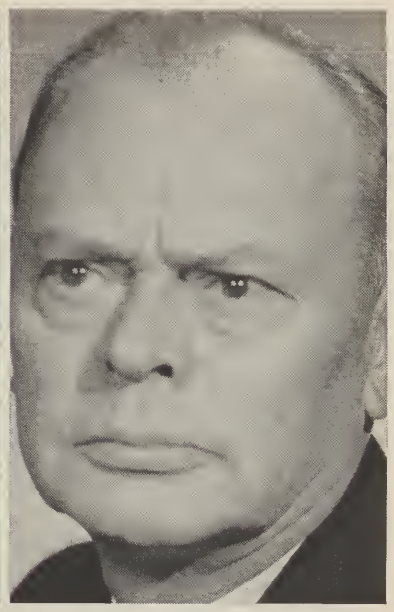
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Each tablet contains:

Salicylamide	250 mg.
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Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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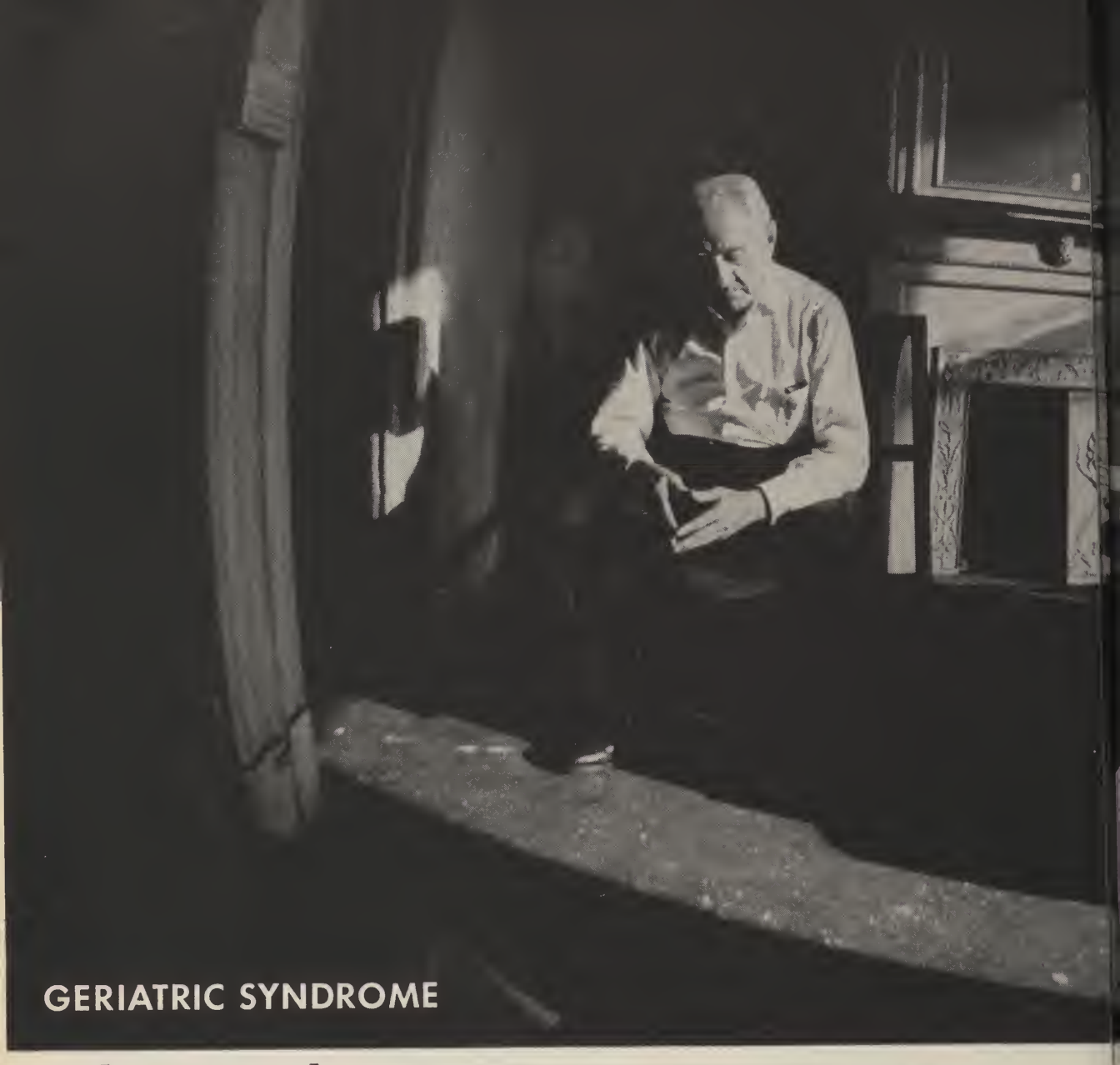
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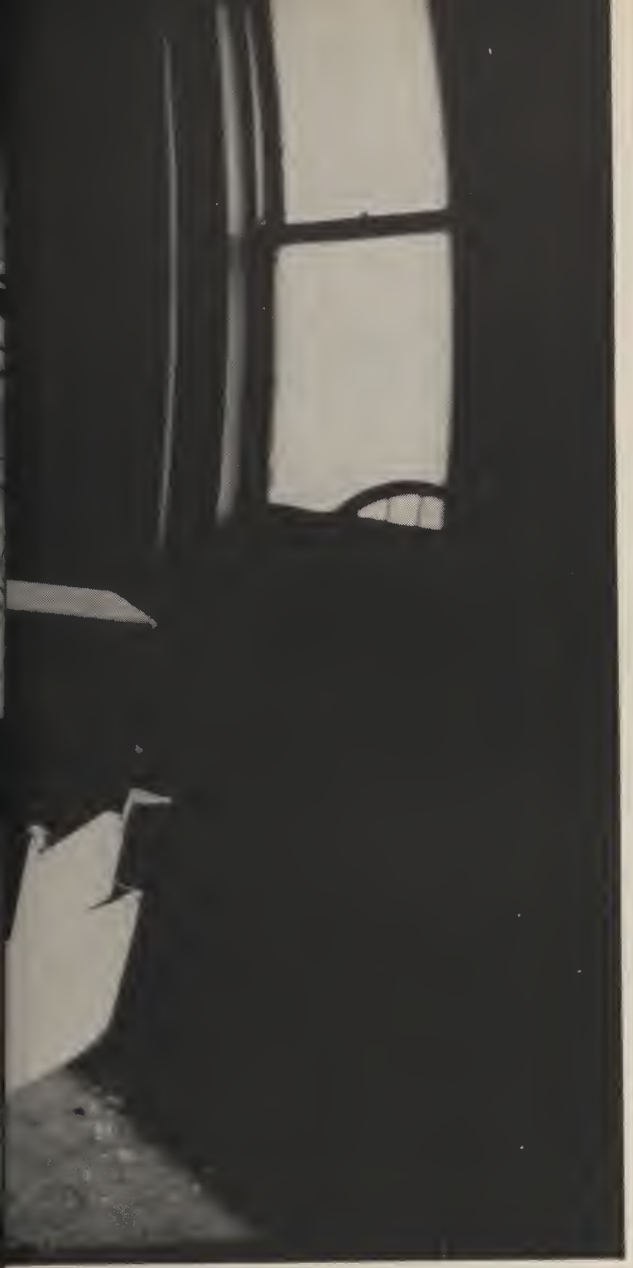
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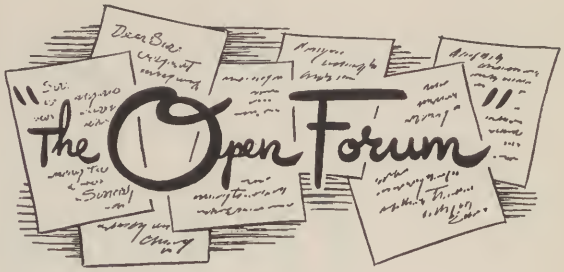
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de effects and precautions: The transitory owsiness which may occur with hydroxyzine Cl usually disappears spontaneously in a few ys with continued therapy, or is correctable dosage reduction. Dryness of the mouth may seen with higher doses. Involuntary motor tivity has been reported in hospitalized tients on higher than recommended doses. ydroxyzine HCl may potentiate CNS depres- nts, narcotics such as meperidine, barbitu- tes, and anticoagulants. In conjunctive use, sage for these drugs should be decreased. cause drowsiness may occur, patients should cautioned against driving a car or operat- g dangerous machinery. **Parenteral Solution ecautions and contraindications:** This dosage rm is intended only for I.M. or I.V. adminis- ation and should not, under any circum- ances, be injected subcutaneously or intra- teriolly. When the usual precautions for I.M. ection have been followed, reports of soft sue reactions have been rare. I.V. adminis- ation should be slow, no faster than 25 mg. r minute, and should not exceed 100 mg. in y single dose. Particular care should be used insure injection only into intact veins; a few stances of digital gangrene occurring distal the injection site have been attributed to advertent intraarterial injection or periarte- al extravasation, both of which should be oided. **More detailed professional informa- n available on request.**



To the Editor:

The vanishing of generalists and the overabundance of specialists carries new problems in its wake: lack of interdisciplinary continuity can and does effect the quality of medical care. Specialists frequently yield to persuasion and practice medicine beyond the boundaries of their specialty.

Within the last few months I have had occasion to witness bad results in a number of such cases as skin diseases in children being treated by pediatricians, a patient with mental depression ill-advised by a dermatologist, and also a surgeon doing synovectomies on successive joints in an otherwise untreated case of rheumatoid arthritis, etc. The resentment over the bad results was, in each case, directed against the medical profession, and it took some talking to quiet the ensuing hostility.

I feel that the total care of these and many other patients is of deplorably low quality. The profession has set up adequate safeguards to keep the generalist and the internist out of the operating room, the delivery suite, and the x-ray lab. The trend of medical practice seems to call for similar safeguards to prevent blundering by specialists who like to "generalize." Perhaps the Specialty Boards should enforce their own regulations against crossing of self-imposed boundaries of practice.

George Vash, MD

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Usual dosage: Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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EXECUTIVE SECRETARY'S NEWSLETTER

April, 1965

ALCOHOLIC COMMITMENTS

Certificates for admitting alcoholics to the state mental hospitals are available from the Department of Mental Hygiene (837-9000, Ext. 591). The VOLUNTARY TREATMENT AGREEMENT FOR ALCOHOLICS requires the indorsement of one physician. For the patient being hospitalized on his family's request, TWO PHYSICIANS' CERTIFICATES FOR ALCOHOLICS ARE REQUIRED.

SPRING REGIONAL MEETING MARYLAND PHARMACEUTICAL ASSOCIATION

The Spring Regional Meeting of the Maryland Pharmaceutical Association is scheduled for Thursday, April 29, at the Washingtonian Country Club, Gaithersburg, Md. The session will open with lunch at 1:00 p.m., followed by the business meeting at 2:30 p.m.

A panel discussion is scheduled for 3:00 p.m. with John F. Schaefer, M.D., acting as moderator; and panelists being Edgar P. Williamson, II, M.D.; B. Martin Middleton, M.D., and Mr. John Sargeant. Cocktails are at 5:00 p.m. followed by dinner at 6:00 p.m.

All physicians are invited. Lunch is $2.50 and dinner $6.00. Tickets may be obtained through the Pharmacy Association.

NEWS NOTES

Drs. Roy and Pearl Scholz are going overseas for a 4-week period working with MEDICO. This is the second time this team has donated its services to this organization.

Nicholas White, M.D., has been certified as a Fellow of the American College of Anesthesiologists.

Certified as Board Members in Anesthesiology are Antonio K. Olmedo, M.D., Baltimore; and Nicholas White, M.D., Catonsville.

Francis A. Ellis, M.D., Baltimore, has been elected a Vice President of the American Dermatological Association. The meeting was held at Boca Raton, Florida.

NEWS NOTES (cont'd)

Ernest L. Stebbins, M.D., is President-elect of the American Public Health Association for 1965. He will become President in 1966.

Timothy Baker, M.D., is serving as Chairman of the Epidemiology Section of the APHA during this current year.

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Your attention is invited to the application for membership in the Maryland Medical Political Action Committee which appears elsewhere in this Journal.

FACULTY ASSESSMENT

In order to clarify some misunderstandings in connection with the $50.00 educational assessment levied by the House of Delegates in special session on February 20, an opinion has been obtained from the Faculty's legal counsel.

In effect, the assessment is an obligation of all Active members, except those in the first and second year of private practice.

As the Bylaws require that it be paid "...with and in the same manner as dues"...members have until the 1966 dues bill is payable in which to make payment to the Faculty office.

Legal counsel advises that 1966 dues may not be accepted until a member is in good standing by payment of the assessment.

"CONTINUING LETTER" COPIES AVAILABLE

Samuel Morrison, M.D., Baltimore City Medical Society President, is writing a series of "Continuing Letters" to the membership. The first in the series was sent to the entire Faculty membership but subsequent copies went to only the members of the BCMS. Copies of the series to date are available through the Baltimore City Medical Society office, 1211 Cathedral St., Baltimore, Maryland 21201.

WELCOME BACK

Two National Pharmaceutical Manufacturers' advertisements appear in this issue of the Journal returning after a lapse of a year or so. These companies are Armour Pharmaceutical and J. B. Roerig. A welcome back is in order to these ethical manufacturers.

John Sargeant

Executive Secretary

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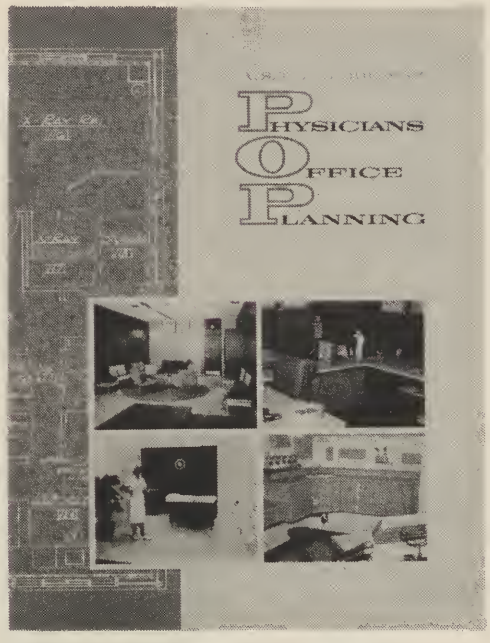
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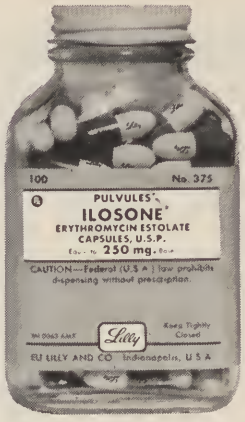
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Ilosone® produces peak levels of antibacterial activity *two* to *four* times those of other erythromycin preparations. Furthermore, it attains them earlier and maintains them longer.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

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Maryland State Medical Journal
Vol. 14, No. 4
April, 1965

Editorial

Doctors and Politics

WHY SHOULD DOCTORS become involved in politics? A physician cannot be apart from the community in which he lives. He is a citizen, a taxpayer, and a patriot. In order to better serve the community at large and his patients, he must either enter politics or allow others to mold the future of the practice of medicine in this country.

In order to serve these laudable aims it is only logical that the physician join his colleagues in political action. How can this best be done? There are two possible courses: He can become a member of his own party organization, or he can join a medical political action group. Better yet, he can do both.

The Maryland Medical Political Action Committee (MMPAC) has four principal objectives: to choose, support, and elect to the United States Senate and House of Representatives qualified persons, whether Democrats or Republicans, who are favorable to the free enterprise system and opposed to government control of the practice of medicine; to do everything legally possible under the laws of our state and nation to accomplish this; to be the political action arm of organized medicine in the state of Maryland; to be bipartisan.

Since its inception in September, 1962, MMPAC has participated actively in three campaigns. As an organization it has made its share of honest mistakes; nevertheless it has become remarkably effective in this short period and has never lost sight of its main goals.

The Executive Committee of MMPAC extends to you a most cordial invitation to join our group in order to make your influence felt in these challenging and troublesome times.

SEE MEMBERSHIP APPLICATION ON REVERSE PAGE

WILLIAM T. LAYMAN, MD
Chairman, Maryland Medical Political Action Committee

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

To the Executive Committee MMPAC,

Date submitted: .....

Gentlemen:

Please accept my application for

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in the category indicated below. I also request Active membership in AMPAC and wish the treasurer to forward $10 of my application fee to that organization as dues. I understand that all memberships are on an annual basis (calendar year).

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Note: In order to properly enroll you as a member, the form below must be completed. PLEASE PRINT. Draw all checks in favor of MMPAC and remit to:

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, DECEMBER 17

1. Installation of a teletype machine was authorized. This will be linked into a teletype network with the AMA and all state medical societies. The only cost to the Faculty will be for messages originated by the Faculty.

2. An insurance company's request to send a letter to Faculty members announcing a new health insurance program, such letter to be on Faculty letterhead and over the signature of the Faculty President, was denied. Publicizing insurance programs is the responsibility of the carrier, not of the Faculty.

3. Approval was given to the establishment of the Vanguard Clinic of Women's Hospital in Towson, subject to the restrictions recommended by the Baltimore County Medical Association.

4. The Executive Committee agreed to lend the Archer Diploma to the University of Pennsylvania Medical School during the observance of that school's bicentennial celebration. The stipulation was made that appropriate insurance be provided and appropriate credit be given to the Faculty.

EXECUTIVE COMMITTEE, JANUARY 21

1. The Medical Advisory Board to the Department of Motor Vehicles asked the Executive Committee's assistance in appointing additional consultants in various specialties to the Advisory Board. The Executive Committee agreed to make appointments from lists submitted by various statewide specialty groups.

2. The Faculty President was authorized to attend the Mid-Atlantic Regional Physical Fitness Clinic in Harrisburg, Pa., or to designate a substitute if he wished.

3. Approval was given to participation in a Voluntary Areawide Health Facilities Planning Agency. Specific proposals as to financing, composition, etc., are to be brought back for approval as they are developed.

4. The Executive Committee approved the principle of a voluntary program of generic drug dispensing in hospitals, subject to the decision locally by hospital medical staffs, as proposed by the Hospital Council.

5. The Gruehn Report on Standards for the Proper Use of Tests was on the agenda for the joint meeting with the Hospital Council, which was scheduled after adjournment of this meeting.

EXECUTIVE COMMITTEE, JOINT MEETING WITH HOSPITAL COUNCIL
EXECUTIVE COMMITTEE, JANUARY 21

1. Announcement was made that a start had been made on implementing the "step-down" method of accounting in all hospitals in the state. This would eventually result in better apportionment of the costs to each hospital department.

2. Report was made of a conference on utilization which had been held in No-

vember; another is planned for the spring. A pamphlet on utilization is being prepared.

3. In discussing the Gruehn Commission Report on laboratory and other tests, use of the word "standards" was questioned. It was agreed that the Faculty should make a critical survey of this whole area and prepare a short report for discussion at a future joint meeting.

4. A progress report was made on the efforts of the Manpower Utilization Committee of the Hospital Council to bring about optimum efficiency of hospital employees.

5. February 15 was set as the expected date for completion of a study of pediatric beds by the Hospital Council.

6. An attempt is to be made to begin studying the costs of physician work. This should cover all areas where physicians are paid a salary by hospitals. Messrs. Pendall and Sargeant are to prepare background data for the next joint meeting.

COUNCIL, JANUARY 28

1. Physicians' Defense was ratified for several members requesting it. Notification was received of settlement of another case in which Physicians' Defense had been granted.

2. The privilege of panel consideration was granted to a physician who had appealed a denial of Physicians' Defense because the event for which suit was brought occurred before the physician had applied for membership. The regular privileges of legal defense, however, were not granted.

3. Emeritus membership is to be recommended for John C. Whitehorn, MD, Harry Linden, MD, and Thomas Vestal, MD, all retired.

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4. The 1965 budget was accepted as presented and as recommended by the Executive Committee subject to reconsideration and representation at the next regular meeting of the Council.

5. The Legislative and Public Relations Committee asked for an appropriation of funds to conduct an educational program in connection with health care legislation. The Council voted to appropriate up to $6,835 with the understanding that the sum will be matched by the AMA. To finance this and continuing educational efforts, a special meeting of the House of Delegates was called to consider levying an appropriate assessment on the membership.

6. Considered and referred to the Liaison Committee was a recommendation that an advisory committee be formed to meet with the Physicians' Services Committee of the Advisory Council on Medical Care, State Department of Health, to discuss mutual problems.

7. Attendance of the senior alternate AMA delegate at Council meetings, without vote, was approved.

8. The following resolution was adopted, and the named groups are to be so notified:

That State Board of Health and Mental Hygiene will direct the Maryland State Department of Health to inform the physicians and public by means of a broad based health education program of the nature, incidence, detection, and treatment of conditions which may lead to mental retardation and other handicapping conditions.

9. Various appointments to the Blue Shield Board and to several committees of Blue Shield were approved.

10. A proposal that Blue Shield withhold some payments to participating physicians for the purpose of a retirement program was rejected. Such a program would lead to loss of Blue Shield's tax exemption and subject premium income to premium taxes.



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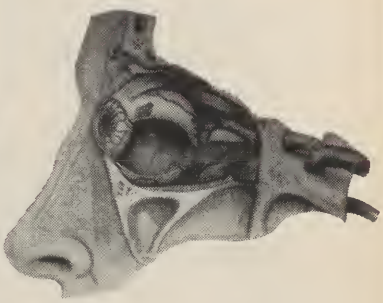
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11. Approval was given to sponsorship of a five-day cruise to Bermuda at the conclusion of the Faculty's 1966 annual meeting.

12. Approval was given to permitting M. B. Levin, MD, to use the Faculty's addressing and mailing services, at the usual fee, for a letter to the membership appealing the ruling of the courts. This was done to ensure that every opportunity was accorded to Dr. Levin in connection with his rights as a Faculty member.

13. The question of financing, editorial content, and a complete study of all aspects of the MARYLAND STATE MEDICAL JOURNAL and its operation was referred to the Policy and Planning Committee for its consideration and report.

14. The question was raised with respect to chiropractors' using the term "chiropractic physician." This matter was still pending before the Board of Medical Examiners, which had reported it to the attorney-general's office for prosecution. It will be pursued again.

EXECUTIVE COMMITTEE, MARCH 4

1. Approval was given to proceed with reclassification of certain staff positions in accordance with work reassignments.

2. The Liaison Committee is to be asked to consider the question of physical examinations of school bus drivers as provided in the budget for the State Education Department. The questions raised concern over freedom of choice of physician and the right of the physician to set his own fee for his services.

3. The report of the Sterilization Subcommittee was formally adopted as Faculty policy, inasmuch as the conclusions of this subcommittee were presented at hearings prior to reintroduction of the sterilization bill in the General Assembly. The report confirms the absence of need for such a law in Maryland inasmuch as adequate procedures now exist for sterilization when indicated.

4. Copies of the revised Medical Practice Act changes were distributed with the understanding that members of the Executive Committee have until April 1 to notify the Faculty office of any areas where further discussion should take place. Approval was given to the definition of the practice of medicine as outlined and one other minor change was made.

5. Approval was given to the mailing of a letter to all Faculty members in connection with the report adopted at the semiannual meeting of the House of Delegates, concerning the Professional Fee Fund. Such letter is to be distributed first to members of the Executive Committee for corrections.

6. Financial aid from the Cordell Fund was approved for 12 months for an ill member who is in need of assistance.

7. Blue Shield is to be requested not to carry statements in its *Physician's Newsletter* such as the one implying that employment of full time physicians in hospitals would reduce hospital costs.

8. Regarding news items in the *Sunpapers* and *News American* about Blue Shield frauds, the following actions were taken: 1) A letter is to be sent to the *Sunpapers*, not for publication, expressing Faculty's concern over such items appearing before verification of the facts had been made. 2) The Mediation Committee is to further investigate the item in the *News American* and to try to learn the name of the physician involved. 3) The physician who protested the appearance of these articles and statements attributed to Blue Shield is to be asked to meet with the staff of the Faculty and Blue Shield, the medical director of Blue Shield, and a representative of the Executive Committee to discuss his comments.

9. Several names are to be submitted to the Governor for appointment to the Advisory

Council on Hospital Construction and to the Governor's Commission to Review Criminal Laws as they Relate to Drug Addicts, etc. Appointments to the Advisory Committee on Medical Education to the State Health Department were approved.

10. Information was received that the Johns Hopkins Hospital Outpatient Services has estabished the following policy: If a privately practicing physician refers a patient to one of the clinics (Johns Hopkins Outpatient Services) either by phone or by letter, the patient's file is flagged for a report to be sent to the referring physician.

11. It was considered satisfactory to accept money sent in from the public to help in the educational program, subject to approval from legal counsel.

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Professional relationships between physicians and attorneys must be improved for the welfare of both professions and of the public. Some major areas of friction concern malpractice suits, the physician in court, and medical reports. The author discusses some of these areas of friction and offers some suggestions for better interprofessional relations.

COOPERATION BETWEEN THE LEGAL AND MEDICAL PROFESSIONS[1]

PAUL BERMAN
Member, Baltimore City Bar

When members of the medical and legal professions sit together and break bread, as we are doing this evening, then the Biblical prophesy that, "The wolf and lamb shall feed together . . ." (Isaiah 65:25) has come true. Unfortunately there is a chasm between the two professions, and the breach seems to be growing wider every day.

It is essential, therefore, not only for the welfare of each profession but also for the welfare of the public, that the professional relationships between physicians and attorneys be improved in order to develop a friendly collaborative spirit under which the medical profession will work with the trial bar in the handling and trial of cases involving personal injuries in a sincere effort to achieve justice.

Various proposals as to how to effectuate improvement in such relationships have been advanced.

Professor Ben F. Small of Indiana University Law School, in an article in 41 *American Bar Association Journal* 693 (August, 1955) said:

> . . . It seems fair to estimate that seven out of every ten contests turn, not upon doctrines of law, but upon medical evidence as to what the particular harm is and what caused it to come about . . . legal institutes have been veering away from the once-popular subjects of taxation, corporate structures, procedure and the like toward legal medicine. In just the past five years, the medico-legal variety of institute has grown to the point of outdrawing, in attendance, any other kind of practitioner training course.

George E. Hall, staff associate of the Law Department of the American Medical Association, advocated meetings of this kind. In an article published in the June, 1954, issue of the *Illinois Bar Journal,* entitled "Let's Understand Each Other," explained the benefit from these meetings as follows:

> . . . These meetings bring together the local lawyers and doctors for an evening of sociability and a discussion of some of their mutual problems. It would be a fine thing if such meetings could be held at least once a year in every county in the state. The result of these meetings is an understanding of each other's problems . . .
>
> To the extent, also, that the attorney, by education, becomes aware of the physicians fears and problems, he will be able to approach the physician more tactfully and with better chance of success . . . The results are sure to be gratifying to both professions and beneficial to patients and clients alike.

[1] Part 1 of a talk entitled "Some Observations by a Trial Lawyer on Cooperation Between the Legal and Medical Professions," given May 23, 1963, at a joint meeting of the Bar Associations and Medical Societies of Allegany and Garrett Counties. Mr. Berman's address will be published in three parts.

In another article, written by Dr. Irving J. Sands of Brooklyn, New York, entitled "Doctors, Lawyers, and Injured Brains" (39 New York State Journal of Medicine 2161 [December 1, 1939]) it was said:

> There should be mutual respect of physicians and lawyers for the responsibilities and attitudes of each other. This would prove a positive contributing factor to judicial verdicts . . .
>
> Appreciation and respect of each others' attitudes and responsibilities would contribute to a better relationship between doctors and lawyers.

It is not necessary to recapitulate all of the grievances of each profession against the other. Most of them are too well known already. Yet it might be helpful to examine with you some of the major subjects of friction between the professions and discuss in a general way what can be done about them.

MALPRACTICE SUITS

High on the list of doctors' grievances is the mounting tide of malpractice actions now being brought. It is natural, although unfortunate, that the physician sued for malpractice will see his true adversary not as the plaintiff but as the plaintiff's attorney. From this, many physicians seem to conclude that lawyers are the cause of the malpractice predicament. From my own experience in this branch of the law, I agree with the statement of Dr. Miley B. Wesson, the author of an article entitled "Medical Malpractice Suits: A Physician's Primer for Defendant," "that *every* malpractice suit, *without any exception,* is instigated either directly or indirectly by a doctor."[1]

The American Medical Association reports that about 14 per cent of all its members in the United States have been subjected to malpractice claims and that California doctors alone have been sued for malpractice at the rate of 25 per cent of its membership. It has been reported that a total of 18,500 of the AMA members have been sued as of mid-1958.[2]

In an artic'e entitled "Why Doctors are 'Bad' Samaritans," in the *Reader's Digest* of May, 1963, page 88, it is said:

> A recent American Medical Association survey revealed that about one in every seven doctors practicing in the United States has been sued for malpractice. In New York, Maine, Arizona, and the District of Columbia, the ratio is one in five; in California, it is one in four.

1. *Medical Malpractice Suits, Cleveland-Marshall Law Review,* Vol. 8, No. 2 (May, 1959) page 254.
2. Ibid.

When published in the newspapers, magazines, and medical journals, these statistics naturally arouse fear and resentment among physicians. But malpractice suits against physicians will not and cannot be abolished. To prohibit such suits would be to condone malpractice. Society cannot and will not tolerate subordination of the public weal to professional conflict or aggrandizement, whatever the profession; medicine, law, or any other. A profession, unlike a business, is primarily for public service and not for personal profitability.

In the states mentioned, the rule of *res ipsa loquitur* is applied, under which it is possible to prove a malpractice case without the aid of expert testimony.

In Maryland and some other states, the rule is different. Our Court of Appeals has held that the doctrine of *res ipsa loquitur* does not apply in malpractice actions against physicians since negligence cannot be inferred from the occurrence alone, and that no inference of negligence or want of skill can be drawn from the result of treatment by a physician, and the mere fact that an unsuccessful result followed medical treatment is not of itself evidence of negligence.[3]

And further, that,

> In medical malpractice cases ordinarily the main issue of the defendant's use of suitable professional skill is a topic calling for expert testimony only.[4]

Those decisions account for the fact that there is no recorded case in our Court of Appeals where a physician has been held liable for malpractice. There is one case in which a dentist was held responsible for pulling the wrong tooth.[5]

So with the well-known "conspiracy of silence" and the decisions of our Court of Appeals, a physician in Maryland is well insulated against suits for malpractice. And lawyers in the state must, as a matter of economic necessity, view with reasonable doubt many of the hysterical complaints against doctors just as they are cautious about accusations of malpractice on the part of other professions.

During the last session of our legislature, an Act was passed that goes even further to insulate the physician against such suits by making all records, reports, statements, notes, and any other

3. *State, use of Kalwes v. Balto. Eye, Ear and Throat Hospital,* (1940), 177 Md. 517; *Lane v. Calvert,* 215 Md. 457 (1958).
4. *State, use of Solomon v. Fishel,* 228 Md. 189, 196.
5. *McClees v. Cohen,* 158 Md. 60.

information which is assembled or procured by any of the medical societies or hospital staff committees that may investigate a malpractice claim against a physician, inadmissible in evidence, and making it a crime to divulge such information (*Chapter 829 of the Acts of 1963,* approved May 6, 1963). That is, all testimony and reports submitted to a grievance committee set up to hear and determine charges of gross negligence from now on must be kept secret. What was up to now very difficult to prove has now been made almost impossible. The last legislature also passed an act generally referred to as the "Good Samaritan Law," which protects a physician who, in good faith, renders emergency care at the scene of an emergency against all claims for damages as a result of any acts or omissions by such physician in rendering the emergency care. This is a good bill.

I am certain that the almost complete immunity now enjoyed by the medical profession in this state against suits for malpractice will not be considered a license to mistreat patients.

Remember, the legislature giveth, and the legislature taketh away; blessed be the name of the legislature.

DOCTORS' RELUCTANCE TO APPEAR IN COURT

Next on the doctors' list of grievances is the lawyers' insistence that he come to court to testify. They cannot understand why the court will not accept a written report, which I have found, on occasion, as hard to obtain as it is to get doctors to come to court. Most doctors detest being required to attend court. They misunderstand the necessity for cross-examination and feel that lawyers proceed by this device to question their professional ability and personal integrity. Doctors should not resent being cross-examined by the opponent of the lawyer who calls them as witnesses. Medical science is not an exact science, and opinions differ between members of the medical profession just as they do in others. When a doctor gives an opinion or states a conclusion, the opposing side has the right to question the validity of such opinion or conclusion and to put it to the same testing to which the opinions of other expert witnesses are subjected. The medical witness stands in the same position as other experts, and the tool for evaluating the probitive value of his testimony is cross-examination. Doctors have told me that one of the reasons for their reluctance to testify is the feeling that while one lawyer is trying to bring out the truth, the lawyer on the other side is trying equally hard to keep the truth from being made known to the judge and the jury.

Wasting time in the court is another reason physicians are hesitant to appear as witnesses. Many of the stories they have heard about doctors cooling their heels in court for hours on end while lawyers argue seemingly obscure legal technicalities are difficult to overcome.

Dr. Sidney Shindel of Connecticut, who is both a doctor and a lawyer, has summed up the typical physician's attitude to a court appearance as follows:

> To the physician, the courtroom means wasting valuable time to give a carefully restricted opinion, necessarily based on inadequate observation, for persons who cannot understand the details of the problem and who probably will not believe him anyway.

To the inexperienced physician, the typical trial lawyer is visualized as an oracle with a silver tongue who delights in mortifying witnesses and who has a mysterious glamor that winds judges and juries around his little finger. Fortunately, this Perry Mason type exists almost exclusively in fiction and the movies.

Physicians are amazed to find that most lawyers are quite human, with very normal reactions, such as respect for a brother profession and a consideration of physicians as their partners in a joint venture—the administration of justice.

Doctors often have just complaints against the legal profession because the privilege of subpoena is abused. I have seen on a number of occasions subpoenae issued for doctors without any advance notice and without advice as to when it is necessary for them to appear. Lawyers must realize that, as in their own profession, the doctors have as their only commodity for sale, their time. And it is the lawyer's responsibility to obtain for the doctor reasonable compensation whenever he takes the doctor's deposition or subpoenas him to appear in court.

We cannot censure the doctor for his distrust of the legal profession when some of the charlatans in our profession, who have promised him reasonable compensation for cancelling office appointments and utilizing that much needed time

to testify in behalf of a litigant, and then finds that the lawyer who promised him a fee suddenly fails to recall any such commitment.

And many doctors have had the experience of spending many hours treating an injured person without funds, trusting him or his lawyer to pay up when the case is settled, only to find that the money has long since been paid and the patient gone. It is the lawyer's duty to see to it that the doctor is paid for medical services out of the proceeds of any settlement or recovery.

ADVICE FOR MEDICAL WITNESSES

Since the things feared most are the unknowns, the AMA Law Department is urging the legal profession to become more active in familiarizing doctors with courtroom procedures and the do's and don'ts which should govern a medical witness. Here are some suggestions to the doctor who has been called to testify:

1. Have no fear. There is no real magic about testifying. Just remember that a courtroom is a place where practical men are engaged in the serious work of endeavoring to administer justice. The honest physician who comes to court to tell the truth has nothing to fear.

2. Don't attempt to testify as an expert unless you are satisfied that you are qualified in the area of specialization involved.

3. Remember to inform your patient's attorney of all unfavorable as well as favorable facts.

4. Be courteous. This, of course, applies to all parties to the proceedings including the lawyers.

5. Don't be smug. A jury is quite likely to react adversely to an attitude of this type. If you are an outstanding character or eminently well qualified, this fact will be apparent to the jury, probably through the efforts of your attorney. A modest attitude on the part of the witness is much more impressive.

6. Tell the truth without reservation or exaggeration. This means, too, that a question should not be answered categorically in all instances. Often the proper answer might well begin with an "if."

7. Don't regard it as an admission of ignorance to indicate that your opinion is not conclusive. To do otherwise is frequently dishonest. Besides, candor and frankness win respect and confidence.

8. Avoid terminology which will not be understood by the jury, the legal counsel, or the judge. The role of the witness is to explain, not confuse.

9. Keep your dignity. Remember that an attorney does not cease to be a gentlemen because he questions you on cross-examination concerning your training, your experience, your integrity, your intelligence, or even your parentage. If his questions are irrelevant, trust the court and jury to attach little significance to them. To lose your temper and attempt to show him up will detract from your effectiveness.

There are really only two trick questions. The opposing lawyer has a right on cross-examination to inquire into the compensation which the doctor has been paid or expects to be paid for attending the trial. The question is relevant and permissible since it goes to his interest in the case. But there is no reason for the doctor to lose his composure when the question is asked. It is usually in the following form: "Doctor, I suppose you are being paid by the plaintiff to testify for him.?"

Your answer should be: "Oh, no, I am being paid only for my time. My testimony is not for sale."

Another trick question is: "Doctor, have you talked to anyone about the case." If he says no, the jury knows that is not true because every competent lawyer will have talked to every witness he expects to use before he puts him on the stand. If he says yes, the lawyer cross-examining him may try to imply that he was told how to testify. The thing to do is to say frankly that you have discussed the case in advance of trial and that your only purpose was to report the facts.

THE LAWYER'S SIDE

High on the list of lawyers' grievances are the difficulty of obtaining the attending physician's presence in court and the almost impossible task of obtaining high calibre physicians as expert medical witnesses.

The medical profession does not want its members to be accused of failing in a civic duty. But there are physicians, some of whom are and some of whom are not eminent in their specialty, who say, "I never come to court. I don't like courts, lawyers, juries, or anything connected with the legal profession." I know one reputedly eminent neurosurgeon in Baltimore who will not even consent to give his deposition in his office unless

he is paid a fee of $250 in advance. That is steep for about one-half hour of his time in his office.

The American Medical Association in 1953 added to its "Principles of Medical Ethics" a new chapter urging doctors to testify. The first portion of that chapter contains the following:

> Physicians, as good citizens, and because their professional training specially qualifies them to tender this service, should give advice concerning the public health of the community. *They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity.* They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary problems, public hygiene and *legal* medicine.

The problem is created by reason of the fact that out of the approximately 180,000,000 citizens of the United States, each year more than 9,000,000 persons are injured, 320,000 permanently, and 90,000 killed as a result of accidents involving automobiles, railroad trains, airplanes, ships, factory and workshop machinery, and in stores, fires, and by electricity. With the increase in population, the tragedy resulting from accident looms even larger in the years ahead.

Since the beginning of World War II, Workmen's Compensation claims attributable to injury and disease occurring in the course of employment have increased to tremendous proportions.[6] As a result, members of the medical profession find themselves called into court to testify more frequently than any other class of experts. The lawyer who practices in the personal injury and Workmen's Compensation fields is acutely aware of the fact that his clients must depend upon the help of the medical profession in seeking a just termination of the litigated claim.

It is not only the duty of the doctor to heal, it is likewise his duty to fairly tell the facts of his patient's injuries and to assist the attorney in clarifying the medical picture to the end that the presentation to the court or commission will be factual and accurate. The doctor's duty in this respect is so well expressed in an editorial in the *Journal of the AMA,* April 21, 1956, that I would like to read it to you.

> The solution of these problems is imperative since, in many cases, the testimony of a physician is absolutely essential to an attorney in the presentation of his client's case. If the attorney is unable to obtain medical testimony, the suit may never reach a jury. Similarly, the physician's records are very important to the attorney. It is generally considered that they have a decided effect on a jury and may be the most telling evidence an attorney has to offer. It is, therefore, of great importance that the physician-lawyer relationship be harmonious and that a physician be readily available with complete and accurate records when called upon to testify.

6. Dean Roscoe Pound, in 1953, (12 *NACCA Law Journal* 197).

MEDICAL REPORTS

With our new rules of practice and procedure, there are no longer any secrets in the trial of a case. Under these new rules, plaintiff's attorney is required to turn over to the attorney for defendant copies of all medical reports in his possession, and the defendant's attorney is required to deliver to plaintiff's counsel copies of all medical reports he has obtained from physicians who have examined the plaintiff on defendant's behalf. We could dispose of cases much faster if the physicians would send us reports relating to treatment of their patients. It is obvious that the medical report is of the greatest importance, first, in trying to dispose of the case by a settlement, and second, in the event the case cannot be settled, in preparing the case for trial. The medical report should include the following points:

(1) a good and accurate history
(2) where and who rendered first aid
(3) complaints
(4) symptoms
(5) dates of examination
(6) treatment rendered
(7) objective signs and findings
(8) x-ray examination
(9) summary of findings
(10) diagnosis
(11) recommendations for evaluation by other specialists, if indicated
(12) opinion as to causal connection between injury and disability and the accident
(13) a prognosis as soon as possible

With the medical report, the doctor should submit a statement of the cost of medical treatment.

INTERPROFESSIONAL CODES

Many bar associations and state medical societies have found that the joint adoption of interprofessional codes has been an effective means of improving interprofessional relations.

One of the best examples of such a code is that which was approved by the House of Delegates

of the State Medical Society of Wisconsin (October, 1954) and by the House of Governors of the Wisconsin State Bar Association (February, 1955). This ten-page masterpiece covers the following subjects:

(1) The attending physician and his patient
(2) The attorney and his client
(3) Conferences
(4) Reports to attorneys
(5) The physician and court arrangements
(6) The attending physician on the witness stand
(7) The attending physician and his charges for services in connection with litigation
(8) The attorney and his direct payment of medical fees
(9) Cooperation by attorney to assure physician payment
(10) Expert testimony
(11) Subpoenaed expert
(12) Statements by physicians to both sides
(13) Ethical limits of medical testimony
(14) Efforts by attorneys to influence medical testimony
(15) The problem of conflicting medical evidence
(16) Choice of language by medical witness
(17) Proper use of professional associations
(18) Interprofessional tolerance

The introduction to this code uses the following language:

> The cause of interprofessional relations will most certainly be well served by this code jointly developed by representatives of the State Medical Society of Wisconsin and the Wisconsin Bar Association. The code is intended to be an instrument for better understanding of the problems existing between attorneys and physicians with reference to medical testimony . . .

In its statement of general principles the code says:

> The attorney represents his client as advisor and confidant, as his advocate in legal proceedings and as negotiator in the business and personal affairs of the client. The physician's relationship is parallel, for he is also the advisor and confidant of his patient in matters of health . . .
>
> Each profession is obligated by its own stature to respect and honor the calling of the other . . .
>
> This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and the law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals . . .

CONCLUSION

In my opinion, the problem of medical-legal relationships, of clogged court calendars, and of unbridled selfishness in a few professional men sworn to public service (it cannot be denied that there are charlatans in both fields of endeavor) are near the point of violent public reaction against both professions.

If the members of the bar and of the medical profession cannot or will not correct the situation —and correct it soon—then the people will: the people represented by politicians who are scornful of both bar associations and medical societies and who are professionals in politics, not in law or medicine.

There may still be time for the lawyers, supposedly the leaders of public opinion and action, to speed up the process of necessary reform. The people will not tolerate much longer the desire on the part of the members of our professions to maintain the status quo at the expense of the public welfare. From my experience and professional association with members of the medical profession for more than 40 years, I am sure they will cooperate wholeheartedly if the courts and the lawyers, on whom the burden of the proper administration of justice rests, will lead the way with courtesy, consideration, and good will. Unless our professions show, by public spirited action, that they have not lost their sense of public mission, I will not venture to predict exactly what form the reaction will take; but I know it will be against the interests of both of our professions and against the best interests of the public.

I believe that it is our duty to prevent such public reaction by a realization and appreciation that we each must and will assist the other toward better interprofessional cooperation, which in the end will result in wholesome benefit to the public generally.

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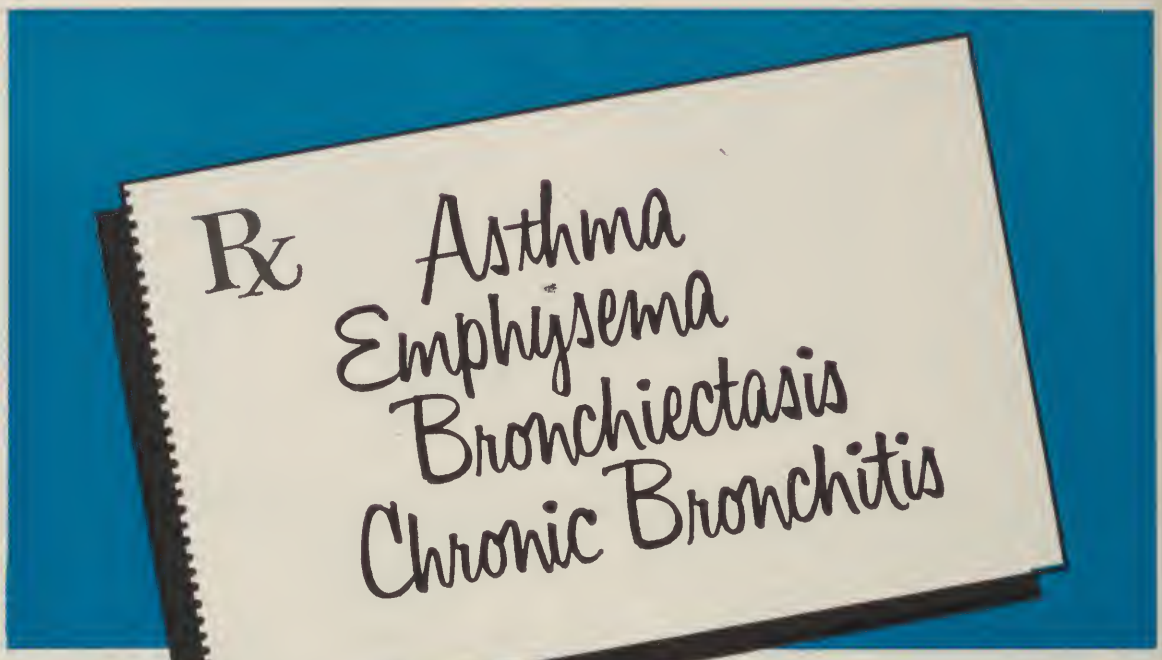
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External Defibrillation and Closed Chest Cardiac Massage in Treatment of Acute Myocardial Infarction Complicated by Ventricular Fibrillation

A 35-year-old man was successfully resuscitated in a community hospital by means of closed chest cardiac massage in conjunction with external electric shock.

Since Kouwenhoven and his associates[1] first described the closed chest cardiac massage for treatment of cardiac arrest, reports from other centers have confirmed its efficacy.[2-5] Successful resuscitation in ventricular fibrillation complicating myocardial infarction has been reported with open thoracotomy and internal defibrillation.[6,7] Zoll and associates[8] developed an effective external cardiac defibrillator which has obviated the necessity for thoracotomy for defibrillation. This report describes one case of ventricular fibrillation successfully treated by the two procedures in a community hospital.

The patient was a 35-year-old Caucasian male. He was admitted to the Emergency Room on February 10, 1963, complaining of chest pain of about two hours duration. The physical examination was unremarkable with a blood pressure of 120/84, pulse 60. The electrocardiogram revealed an acute posterior wall myocardial infarction. When lead VI was being taken, he suddenly complained of severe chest pain, developed generalized tonic and clonic convulsions, and showed evidence of ventricular fibrillation (Fig. 1). No pulse or blood pressure could be obtained. Closed chest cardiac massage, endotracheal intubation, and intravenous metaraminol bitartrate (Aramine) were immediately started, with continuous oxygen. He then received 250 volts. Since ventricular fibrillation persisted, he received 15 more countershocks of 450 volts each until a sinus rhythm was obtained (Fig. 1) with evidence of an acute posterior myocardial infarction. The intravenous infusion had to be discontinued because of tissue infiltration, and the blood pressure returned to normal upon establishment of a sinus rhythm. The patient became violent, irrational, and confused; he had to be restrained and heavily sedated with intravenous sodium luminal (480 mg). Two hours after the defibrillation he was oriented.

RAFAEL A. PEREZ-MERA, CAPT MC
Medical Officer, Department of Medicine, Kimbrough Army Hospital
and
CHARLES E. SHIELDS, MAJOR MC
Chief, Laboratory Service; Assistant Chief, Medical Service, Kimbrough Army Hospital

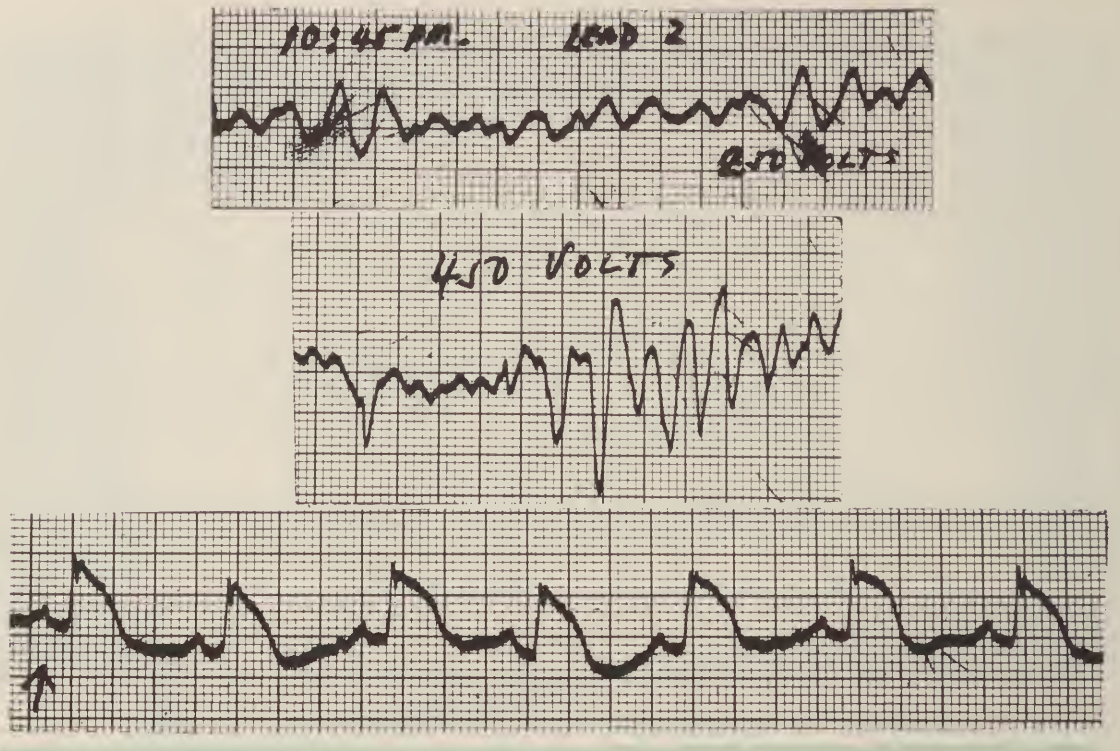


Fig. 1
Electrocardiogram showing ventricular fibrillation and sinus rhythm.

Past medical history and review of systems: In 1951 in Korea he had a singular episode of numbness and weakness of the left arm lasting about 10 minutes. One year ago he had sudden stabbing precordial pain while watching television, lasting about seven minutes, with some "spasm" of the left arm. On January 7, 1963, he was brought to the emergency room because he awoke with heavy breathing and sharp retrosternal sticking pain. He then noted numbness and apparent paralysis of the left hand and leg. On trying to stand, he fell to the floor. He never lost consciousness. Symptoms disappeared in five to ten minutes. He was then hospitalized for further evaluation. The physical examination was normal. Complete blood count, cardiolipin microflocculation, fasting blood sugar, blood urea nitrogen, urinalysis, SGOT, chest and skull x-rays, and two electrocardiograms were all within normal limits. The patient was discharged after four days of observation.

Hospital course: On February 11, 1963, he was noted to have occasional ventricular premature beats in the cardioscope. Two hours later he had frequent ventricular premature beats, two and three in succession. Oral quinidine, 200 mg every three hours, was started, and the extrasystole rapidly disappeared. His vital signs remained in the normal range, and the rest of the hospital course was uneventful.

DISCUSSION

The method of closed chest cardiac massage applied in this case has been described by Kouwenhoven and co-workers.[1] Thumping of the precordium has been used with success in ventricular standstill.[9] Closed chest cardiac massage and external defibrillation have been applied successfully in ventricular fibrillation complicating cardiac catheterization[10,11] and in newborn infants.[12]

Our patient received 16 countershocks before final sinus rhythm could be established. There was temporary mental deterioration without permanent brain damage. The vasopressor had to be discontinued because of tissue infiltration due to the patient's restlessness, but blood pressure returned to normal upon establishment of a sinus rhythm. About four hours after defibrillation, runs of ventricular premature beats were seen in

the electrocardioscope, disappearing rapidly with oral quinidine. The rest of the hospital course was uneventful, and the patient has had no further complications.

To our knowledge, this is the youngest patient reported with acute myocardial infarction complicated by ventricular fibrillation successfully resuscitated by closed chest cardiac massage and external defibrillation.

There are direct complications associated with closed chest cardiac massage that may be fatal[13,14]. Clark[15] reported a wide variety of complications in 19 cases. Nachlas et al[16] developed a portable pneumatic pump for external cardiac massage, and in their experiments they did not report any of the usual complications of the manual closed chest technique.

We would like to stress the statement of Keevil et al[2]:

> Any hospital that undertakes to admit and care for patients with acute coronary thrombosis should have staff physicians available to recognize ventricular fibrillation by electrocardiogram and a staff trained in the techniques of closed-chest cardiac massage and defibrillation.

The successful treatment of the young patient reported here emphasizes the need for this procedure in the emergency room.

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GENERIC AND TRADE NAMES OF DRUGS
Metaraminol bitartrate—*Aramine bitartrate*

REFERENCES

1. Kouwenhoven, W.B., Jude, J.R., Knickerbocker, G.G.: Closed-chest cardiac massage. JAMA 173:1064-1067, 1960.
2. Keevil, C.S., Bordman, D.W., Wagner, S.H.: Ventricular fibrillation in a community hospital: treatment by closed-chest cardiac massage and external defibrillation. *New Eng J Med* 268:307-309, 1963.
3. Barringer, J.R., Salzman, E.W., Jones, W.A., Freidlick, A.L.: External cardiac massage. *New Eng J Med* 265:62-65, 1961.
4. Moss, A.J., Osborne, R.K., Baue, A.E., Less, R.S., Jamison, R.L. and Spann, J.: Closed-chest cardiac massage in the treatment of ventricular fibrillation complicating acute myocardial infarction: report of three cases with survival. *New Eng J Med* 267:679-681, 1962.
5. Jude, J.R., Kouwenhoven, W.B., Knickerbocker, G.G.: Cardiac arrest: report of application of external cardiac massage on 118 patients. JAMA 178:1063-1070, 1961.
6. Bloomfield, D.X., Mannick, J.A.: Successful resuscitation in acute myocardial infarction with ventricular fibrillation: report of a case. *New Eng J Med* 258:1244-1247, 1958.
7. Sussman, I.: Successful thoracotomy and cardiac massage in a case of apparent sudden death due to acute myocardial infarction. *Amer J. Cardiol* 10:124-127, 1962.
8. Zoll, J.M., Linenthal, A.J., Gibson, W., Paul, M.H., Norman, L.R.: Termination of ventricular fibrillation in man by externally applied electric countershock. *New Eng J Med* 254:727-732, 1956.
9. Scherf, D., Bornermann, C.: Thumping of precordium in ventricular standstill. *Amer. J Cardiol* 5:30-40, 1960.
10. Ryan, N.J., Cayler, G.G.: Ventricular fibrillation during cardiac catheterization: successfully treated with external defibrillation and closed-chest cardiac massage. *Amer J Cardiol* 10:120-123, 1962.
11. Sasahara, A.A., Rudolph, A.M., Hoffman, J.E., Hauck, A.J.: Ventricular fibrillation during catheterization of the right side of the heart terminated successfully by external defibrillation. *New Eng J Med* 261:26-29, 1959.
12. Mathews, D.H., Avery, M.E., Jude, J.R.: Closed-chest cardiac massage in the newborn infant. JAMA 183:964-966, 1963.
13. Morgan, R.R.: Laceration of the liver from closed-chest cardiac massage. *New Eng J Med* 265:82-83, 1961.
14. Perez-Mera, R.A.: Unpublished data.
15. Clark, D.T.: Complications following closed-chest cardiac massage. JAMA 181:337-338, 1962.
16. Nachlas, M.M., Siedband, M.P.: A simple portable pneumatic pump for external cardiac massage. *Amer J Cardiol* 10:107-109, 1962.

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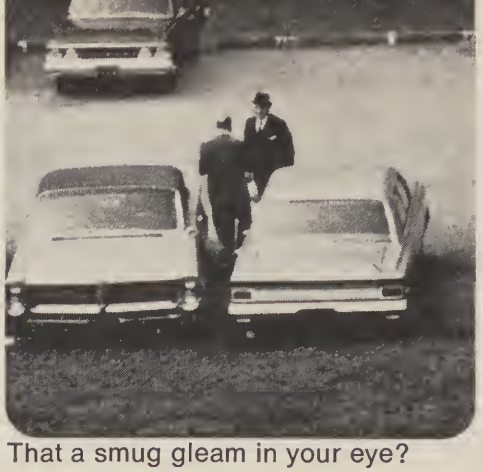
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ENDOLYMPHATIC-SUBARACHNOID SHUNT OPERATION FOR TREATMENT OF MENIERE'S DISEASE:

Report of a Case

This conservative procedure appears to relieve the symptoms of Meniere's disease and improve the patient's hearing.

NORMAN BLANKMAN, MD

THIS IS THE REPORT of a patient with disabling Meniere's disease who failed to respond to conservative management and subsequently did show dramatic results with surgery to provide drainage of the endolymphatic fluid through a shunt into the subarachnoid space. This procedure was originally reported by William House, MD, and his associates and represented a refinement of a procedure originally described by G. Portmann, MD, of Bordeaux, France, in 1927.

The cause of Meniere's disease remains obscure. The gross pathological findings are marked distention in the endolymphatic system and degenerative changes in the inner ear. Endolymphatic hydrops could be due either to overproduction or under-absorption of endolymphatic fluid; both theories have their supporters. Regardless of the mechanism of absorption of endolymphatic fluid, which also is not well understood, the endolymphatic sac seems to function as an emergency reservoir to stabilize the endolymphatic system.

Medical treatment of Meniere's disease follows a great many paths. Because of its recurrent nature, the therapy has always been difficult to evaluate and a multitude of drugs and regimen have been employed with varying success. When medical therapy fails and vertigo persists, surgery to provide endolymphatic drainage is advisable.

CASE REPORT

A 64-year-old Caucasian man had been observed as an office patient for about two years. At the time of his initial visit, he had suffered for several years with intermittent episodes of nausea, rotatory vertigo, and right ear fullness with diminished hearing. These were described as being sudden in onset, lasting for several minutes to one hour, and often recurring frequently over a period of several days. He continued to have difficulty in spite of treatment with vasodilaters, propantheline, large doses of B vitamins, and eustachian tube inflation. An episode of scarlet fever at age 12 had left him with a severe hearing impairment in his left ear. He did not complain of tinnitus in the left ear, nor had he been aware of any further progression in the hearing loss on the left side, but the hearing on the right had gradually declined for the past

several years and there was a marked feeling of pressure. Symptoms in his right ear had become so incapacitating that he had to be retired from his job.

On physical examination the only noteworthy finding was the audiogram, which showed an average 75 decibel hearing loss in the left ear with no significant bone-air gap and an average 72 decibel hearing loss on the right with some further high tone decline. Speech discrimination revealed a 34% at 90 decibels on the right and an 8% at 92 decibels on the left. Recruitment tests were not possible because of the limitation imposed by the patient's severe hearing loss. Both labyrinths functioned normally according to the minimal icewater tests.

With the patient under general anesthesia, a subarachnoid shunt operation was performed for drainage of the endolymphatic sac. A postauricular incision was made and an extensive simple mastoidectomy was done with use of the operating microscope. The mastoid was not well pneumatized, making for difficulties in skelatonizing the labyrinth, but ultimately the structures were well defined. The thin bony plate of the posterior fossa between the skelatinized posterior semicircular canal and the lateral dural sinus was removed. The endolymphatic sac was isolated after its location as an adherent thickening in the exposed dura posterior-inferior to the posterior semicircular canal. The sac was opened and a short perforated polyethylene tube was inserted through the medial wall of the endolymphatic sac and through the meningeal dura of the posterior cranial fossa. Because of the marked flow of the cerebrospinal fluid at this time, the cavity was packed with gelatin sponge reinforced with iodoform gauze. The postauricular incision was closed in the usual fashion.

The patient received antibiotics throughout his 10-day hospitalization. Except for cerebrospinal fluid otorrhea on the first day, his postoperative course was uneventful. The iodoform packing was gradually removed during the first four postoperative days, and the sutures were removed on the seventh postoperative day.

At no time since the patient's operation has there been any vertigo; this, surprisingly, was absent even on the first postoperative day. In the eight months before surgery, the patient had had daily attacks of vertigo and almost constant tinnitus, was not able to work, and was afraid to leave the house because of the severity of his dizziness. At this writing, seven months after his operation, he has remained totally asymptomatic. The tinnitus had almost entirely disappeared from his right ear by the third postoperative day. This was accompanied by improvement in his hearing, which had risen from an average preoperative loss of 72 decibels to a present level of 55 decibels.

The patient's emotional outlook has greatly improved, and he has been able to return to complete normal activity.

DISCUSSION

One case hardly makes a series, and seven months is not a lifetime, so a prolonged study of a larger group is certainly needed. However, the dramatic improvement in this patient and the great benefits observed by Dr. House and his group in a larger number of patients indicate the usefulness of this type of surgical intervention.

This procedure seems to allow prolonged symptomatic relief of Meniere's disease while improving hearing. It may provide permanent relief in a physiologic fashion through the use of a persistent shunt to stabilize the endolymphatic balance. It is considerably less extensive than craniotomy for sectioning of the vestibular branch of the auditory nerve. It is also a more readily acceptable procedure than a destructive labyrinthectomy, which provides symptomatic relief but necessitates sacrifice of the residual hearing.

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GENERIC AND TRADE NAMES OF DRUGS
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REFERENCES

1. House, W. F.: *Laryngoscope* 72:713-729 (June) 1962.
2. Portmann, G.: Vertigo, Surgical Treatment by Opening Saccus Endolymphaticus, *Arch Otolaryng* 6:309-319 (Oct) 1927.
3. Portmann, G.: Saccus Endolymphaticus Operation for Draining Same for the Relief of Vertigo, *J Laryng* 42:809-817 (Dec) 1927.
4. Hallpike, C. S., and Cairns, H.: Observations on Pathology of Meniere's Syndrome, *J Laryng* 53:625-655 (Oct) 1938.
5. Cawthorne, T.: The Surgical Treatment of Meniere's, *Laryngoscope* 73:1010-1021 (Aug) 1963.

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References: **(1)** Warres, H. L.: *Missouri Med.* 61:27, Jan., 1964. **(2)** Palmer, K. J.: *Week. Urol. Clin. Letter* vol. 6, no. 36, Dec. 24, 1962. **(3)** Carroll, G.: *J. Urol.* 90:476, Oct., 1963. **(4)** Ward-McQuaid, J. F. N. C.; Jichlinski, D., and Macis, R.: *Brit. M. J.* 2:1311, Nov. 23, 1963.

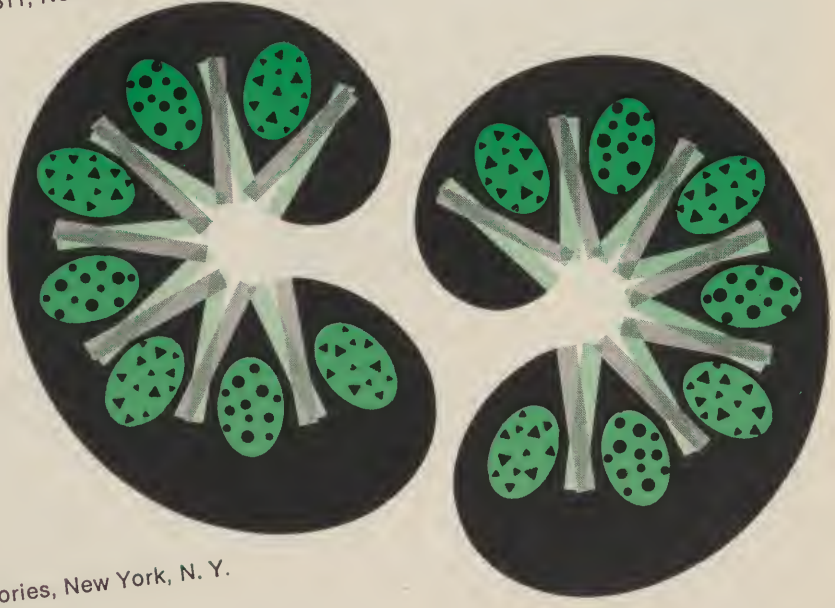
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BALTIMORE CITY

Osler Hall was packed for the first scientific meeting of the year. The members got what they wanted in a series of brisk 10-minute papers on "Disorders of the Digestive Tract." This is a stunning triumph for **Dr. Morrison.** As president, he chose to be chairman of his own Program Committee and devoted many months to planning. The success of this meeting bore out his philosophy that lively meetings can be anticipated without requiring an expert from out of town.

There's more to come. Following are the programs already planned for the fall and winter:

Friday, October 1

1. "Breast Cancer," **Edward F. Lewison, MD,** assistant professor of surgery, The Johns Hopkins University School of Medicine.
2. "Use and Misuse of Pharmacotherapy in Migraine," **William G. Speed, III, MD,** assistant professor of medicine, The Johns Hopkins University School of Medicine.

Friday, November 5

"Medical Education—Its Direction," **Samuel Morrison, MD, moderator.**

Participants:

1. **William S. Stone, MD,** director, Medical Education and Research, and dean, University of Maryland School of Medicine.
2. **Thomas B. Turner, MD,** professor of microbiology and dean of the medical faculty of The Johns Hopkins University.
3. **Warde B. Allan, MD,** associate professor of medicine, The Johns Hopkins University School of Medicine.
4. **E. S. Ellison, MD,** former chief of staff, Franklin Square Hospital.
5. **William F. Renner, MD,** chief of staff, Union Memorial Hospital.
6. **George H. Yeager, MD,** professor of clinical surgery, University of Maryland School of Medicine.

Friday, January 7

1. "Suppurative Infections of the Liver and Biliary Tract," **Theodore E. Woodward, MD,** professor of medicine and head of the department, University of Maryland School of Medicine.
2. "Management of Portal Hypertension and Its Complications," **George D. Zuidema, MD,** professor of surgery and director of the Department of Surgery, The Johns Hopkins University School of Medicine.

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The Speakers Bureau went into high gear in February and March with a series of engagements. Speaking on health care legislation were **Raymond M. Yow, MD,** and **Osborne D. Christensen, MD.** Dr. Yow appeared before the Young Republicans Club on March 11, and Dr. Christensen surveyed current proposals before Congress for the Salisbury Lions Club.

Daniel Anderson, MD, discussed summer health care for children, at a meeting of the Four Corners Homemakers Club; and **James Clifford, MD,** gave a presentation on food fads for the Salisbury Exchange Club. **A. C. Kolls, MD,** appeared before the Nanticoke Elementary PTA. His topic was school health.

In addition, the Speakers Bureau provided a refresher series of lectures on emergency first aid for the volunteer fire companies and rescue squads of Worcester County. Participating in these were **William Sadler, MD, Robert L. Baker, MD, Wilber Ellis, MD, Paul G. Cayaves, MD,** and **Marcus Stephanides, MD.** Topics included cardiac massage and mouth-to-mouth resuscitation, sunstroke and heat prostration, emergency deliveries, first aid for fractures, and emergency treatment of burns.

A mass tetanus immunization program was staged by the Wicomico County Medical Society, Inc., during the annual Jaycee Sportsman's Show in the Wicomico Youth and Civic Center, February 26-28.

Free tetanus toxoid was provided to all who wished it. A booth was set up in the lobby of the show throughout the three-day attraction in Salisbury. The medical society purchased the vaccine and supplies and handled publicity, both through its society office and through contacts made by members of the Womans' Auxiliary. These ladies visited a PTA meeting in each of the schools throughout the city, handing out tetanus literature and explaining the program. Excellent cooperation was received from news media, including the lead editorial in Salisbury's *Daily Times.*

Space for the booth was provided free of charge by the Jaycees. Registrations were handled by

women of the Auxiliary, and student nurses from the Peninsula General Hospital School of Nursing gave the shots under the supervision of a member of the society. Although no charge was made for the shots, voluntary contributions were accepted and turned over to the Peninsula General Hospital Building Fund.

Participating in this project were **Seth Hurdle, MD, Rufus Gardner, MD, Marcus Stephanides, MD, William B. Smith, MD, G. Herbert Sembly, MD, Oswald Burton, MD, Charles Bagley III, MD, Frank Poole, MD,** and **William Fritz, MD.** In charge of arrangements was our president, **Andrew C. Mitchell, MD** who began plans late in 1964 while he was public relations chairman.

Mrs. Kit Hargreaves



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TO THE COMMUNITY

Chevy Chase Nursing and Convalescent Center, Inc., of Silver Spring, Maryland, has been accredited as an intensive nursing care facility, it was announced by Henry A. Holle, M.D., Executive Director of the National Council for the Accreditation of Nursing Homes.

This facility, headed by Mr. Harold Behrmann, has been awarded this distinction on the basis of a recently completed survey by a field representative of the Council.

The National Council was established in April, 1963, under the sponsorship of the American Medical Association and the American Nursing Home Association to promote standards of professional care of high quality in the operation of nursing homes throughout North America.

The Chevy Chase Nursing and Convalescent Center is the only Nursing Home in this area to be so accredited, and there is only one other Nursing Center which has been awarded this distinction in the State of Maryland.

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1964 REPORT

On Activities of
The Maryland Society of Pathologists

PART 2

THE PARTICIPATION IN THE HEALTH Evaluation Survey for Maryland physicians attending the Annual Meeting of the Medical and Chirurgical Faculty was a satisfying undertaking. Under the chairmanship of Charles Petty, MD, the committee consisted of Joseph Workman, MD, and Mrs. Genevieve Ritchie, representing the Medical and Chirurgical Faculty; Leonard Scherlis, MD, representing the Maryland Heart Association; S. M. Wolff, MD, representing the Maryland Ophthalmological Society; Robert Cavenaugh, MD, representing the Maryland State Health Department; Mr. Larkin Caples, MT (ASCP), representing the Maryland Society of Medical Technologists; and Doctors R. Lancaster, W. B. King, Jr., H. H. Marsh, and R. Katase, representing the Maryland Society of Pathologists. This committee organized a program in which approximately 200 physicians underwent a series of screening tests. In spite of the tremendous work involved, this endeavor demonstrated that different groups and organizations could work together cooperatively and give leadership to the rapidly developing area of health evaluation and health maintenance. Analysis of the data obtained formed the basis for the Maryland Society of Pathologist's first formal joint program at the Medical and Chirurgical Faculty Meeting in September, 1964, at Ocean City.

One of the common goals in laboratory medicine is close cooperation between pathologist and medical technologist. The Joint Committee for Educational Programs (composed of members from the Maryland Society of Medical Technologists and our society) sponsored several seminars and recruitment activities. Our society contributed $250 to the Maryland Society of Medical Technologists' scholarship fund, which includes the Ann Hellen Memorial Fund for postgraduate study and undergraduate student loan fund. We continue to urge and work toward the establishment of a school of medical technology at the University of Maryland.

Through the Pathology Page in the MARYLAND STATE MEDICAL JOURNAL we attempt to communicate to the physicians of Maryland the developing trends and newer concepts in pathology. W. Bradley King, Jr., MD, has done an excellent job as editor during the past three years.

The cost of medical care is a direct responsibility of each of us. Many members of the society volunteered their time to work with the Governor's Committee to Study Hospital Costs.

Society members participated formally in the National Science Fair International, the Diabetes Detection Week, the formation of the Red Cross Public Unit for Life Saving Emergency (PULSE), unique to Baltimore, the formulation of a blood procurement program for open heart

ROBERT Y. KATASE, MD
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surgery by the Red Cross, and in the formation of the Baltimore Metropolitan Coordinating Blood Council, as well as on the committees appointed by the council.

Under the able leadership of Robert Cavenaugh, MD, Membership Committee chairman, society membership rose to 103.

Watson Kime, MD, secretary-treasurer, reports that our financial structure is sound in spite of the many demands for support of increasing numbers of activities.

Space does not permit mentioning the accomplishments of many other dedicated people. It would seem, though, that activities such as described in this report do more to demonstrate to the public and re-emphasize to our fellow physicians that pathologists are physicians practicing within the self-imposed ethics and discipline of medicine. As pathologists, in common with all physicians, we must be able to communicate with and demonstrate to the public that we support and practice the concept of professionalism with attendant self-discipline, continuing education, responsible leadership, and maintenance of professional freedom.

Reflecting the medical progress and the changing nature of medical practice, pathologists are moving out from the traditional "paraffin curtain and dead house" and are combining the methods and techniques of laboratory science with the dynamics of clinical medicine. Such an exciting development has attracted many physicians into the field. This scientific endeavor requires intense basic training and continuing education. Many of these pathologists are assuming responsibilities in both hospital and private laboratories. By virtue of their training and continuing association with medical schools, research centers, and state and national professional societies, they are able to make available procedures ranging from quality-controlled blood glucose levels to histopathologic, cytologic, cytogenetic, radioisotopic, immunologic, and electron microscopic studies, as well as to keep abreast of other rapidly developing parameters.

The rapid progress in medicine clearly indicates that the best interest of the patient will be best served by these trained physicians developing the laboratory resources in close cooperation with and support by our clinical colleagues. Under professional guidance, the same resources can be applied to research, teaching activities, experimental pathology, and the development of new techniques and applications.

We need the informed and active support of all physicians if we are to deal effectively with the powerful forces that are attempting to label the products of our professional training and experience as "goods" rather than services, or the mushrooming problem of "gray zone," non-physician directed laboratories, organized solely for profit and without the best ethical control of such evils as fee-splitting, rebates, and "sink" tests. Another problem of great concern is the ramification of pathologists' services being classed as "hospital services" by insuring agencies and in many proposed legislations.

In closing, I would like to express my appreciation for the honor of serving the society during this past year. It has been a great experience. I know that the newly elected officers will do their best to meet the challenges that lie ahead on behalf of the society members and the physicians of Maryland.



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The Heart Page

George C. Roveti, MD—*Editor*

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The Need for Objective Assessment of Cardiac Symptoms

G. C. FRIESINGER, MD

OBJECTIVITY IN THE EVALUATION of clinical problems has always been emphasized. Anxiety is associated with the diagnosis or suspected presence of cardiac disease, and it is important to get objective information on the origin of the symptoms.

The patient with cardiac disease may see the physician because of any one (or several) of a wide variety of complaints. In most instances, the complaint is subjective and qualitative. Fatigue, dyspnea, palpitation, and pain are the most frequent complaints the patient voices; less commonly, syncope or cerebral symptoms. Usually careful history taking and examination and properly selected simple laboratory tests will confirm whether or not the symptoms are cardiac in origin. In many instances, it may not be possible for the physician to reassure the patient that serious cardiac disease is not present even though it is possible that symptoms are not of cardiac origin and, in some instances, trivial as regards their implications.

To avoid anxiety and manage such problems realistically, it is important to use all reasonable means to reach a diagnosis. Most effective in this regard is to reproduce the complaint under observation and monitor the patient in such a way that objective documentation of the problem is possible.

Often this can be effectively done by simple maneuvers at bedside or in the office. One can sometimes demonstrate that the usual tachycardia produced by mild exercise gives the palpitations which constitute the patient's complaints, ie, he has an increased awareness of heart-action, but paroxysmal tachycardia or other arrhythmia probably is not producing his symptoms. On the other hand, exercise may produce premature contractions which sometimes are interpreted as uncomfortable sensations in the chest. If the patient is especially aware of their occurrence, he may interpret them as being due to serious cardiac disease.

Similarly, the Valsalva maneuver can sometimes produce premature ventricular contractions with the blood pressure and heart rate changes accompanying this vagal stimulation. In addition, even mild exercise may make it apparent that a patient hyperventilates; or merely having the patient hyperventilate may produce the complaints of giddiness, vague chest discomfort, and paresthesias which are a part of his symptom complex.

More formal exercise testing, with a two-step or bicycle ergometer with the electrocardiogram, may provide the diagnosis. Recently, we have used a lightweight lead system which allows recording of a high quality 12-lead electrocardiogram *during* exercise.[1] The construction and use of this lead system is simple enough that anyone willing to devote the time and patience necessary can obtain

satisfactory tracings. A variety of similar lead systems which allow good quality electrocardiograms during exercise have been devised by others.

Such testing under *physician supervision* has several advantages in addition to those accruing from the observation of the exercise effort per se. Instead of submitting all patients to a standard exercise load (adjusted for such factors as age, etc.), monitored exercise of this nature allows one to "push" exercise to a reasonable maximal load for the specific patient. Maximum heart rates which can be achieved relative to age have been determined.[2,3] Since the electrocardiogram is being viewed during exercise, arrhythmia, ischemic change, or other significant abnormalities can be immediately appreciated and exercise curtailed if necessary.

A "standard" step-test may produce virtually no tachycardia in one patient while the same physical effect may accelerate the heart rate 30 or 40 beats per minute in another patient. Coronary blood flow and cardiac output are certainly related to this heart rate change; hence the actual stress put on the cardiovascular system is vastly different in two such patients. Therefore, a standardized stress test is more rationally standardized as regards the patient's response in the form of heart rate increase rather than a number of trips over the steps predetermined in an arbitrary fashion. With this type of equipment arrangement and attitude toward stress, we have found ischemic ST segment abnormalities ("square" wave ST segment depression of 1 mm or more) in a number of patients where the standard step-test did not produce pain or electrocardiographic changes. In other instances, we have recorded ischemic electrocardiographic changes during exercise which have disappeared in the minute or so required to have the patient lie down. In this latter instance, conventional exercise testing where the tracings are recorded only in recumbency would have failed to show the diagnostic electrocardiographic changes.

Another value of exercise under physician supervision is that it will be obvious to the patient that the exercise effort under such "controlled" conditions is not harmful. Often patients with chest pain of possible coronary origin have concluded for themselves or on the basis of well-meaning physician's comments that exercise should be approached with great caution or avoided lest the pain of possible coronary artery origin occur.

In the patient whose complaints suggest a serious paroxysmal arrhythmia but who is found to have no rhythm disturbance on repeated examination in the asymptomatic phase, hospitalization with continuous electrocardiographic monitoring is reasonable. The tracing can be viewed on an oscilloscope or recorded on magnetic tape. Such a plan is feasible only if hospital personnel can be familiarized with the equipment arrangements and the suspected arrhythmia occur with reasonable frequency.

If a cardiac cause is not found for the patient's complaints, a similar objective approach should be made in other areas where symptoms could originate. The assessment of an esophageal source of pain which may simulate coronary insufficiency has been mentioned. X-rays of the cervical spine, movement of the neck and shoulders in an effort to induce pain, and exerting pressure at various points about the rib cage are simple maneuvers which may provoke the patient's pain and allow one to conclude that his problems are trivial. Similarly, it is sometimes important to consider with the patient the psychoneurotic possibilities when all reasonable evaluation has failed to disclose a functional cause for symptoms.

Many kinds of maneuvers can be used to objectively define a patient's symptoms. The problems under discussion here start as and remain basically clinical in nature, and the key to their solution is critical history taking. Simple maneuvers to reproduce the pain should never be overlooked, and more elaborate kinds of evaluation should be used when necessary. To manage these problems properly is a time consuming task for the physician, regardless of his skill and experience and in spite of the fact that a wide variety of specialized techniques are available to him.

REFERENCES

1. Mason, R. S., Likar, I., and Ross, R. S.: New system of multiple lead in exercise electrocardiography compared with coronary arteriography. *Circulation* 30:123 (Supp III), 1964.
2. Robinson, S.: Experimental studies of physical fitness in relation to age. *Arbeits physiol* 10:251:1938.
3. Sheffield, L. T., and Reeves, T. J.: Graded exercise in the diagnosis of angina pectoris. *Mod Conc Cardiov Dis* 34:(Jan) 1965.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

The TRAUMA Page

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G. Schmeisser, Jr., MD, Editor



GAYLORD L. CLARK, JR., MD
Instructor in Orthopedic Surgery
The Johns Hopkins University School of Medicine

From the Hand Clinic, Baltimore City Hospitals

Fig. 1
NORMAL ANATOMY

A. Extensor tendon attachment to distal phalanx.
B. Flexor tendon attachment.
C. Lateral view. Note the volar plate interposed between the flexor profundus tendon and the joint.

Several Methods of Treating

Distal Phalangeal Fractures

Editor's note: In this contribution, a script in the conventional sense has been omitted. The editor hopes the reader will agree that the author has blended his personally drawn illustrations and descriptive legends in a form which conveys his thoughts with beauty and precision, eliminating the need for further words.

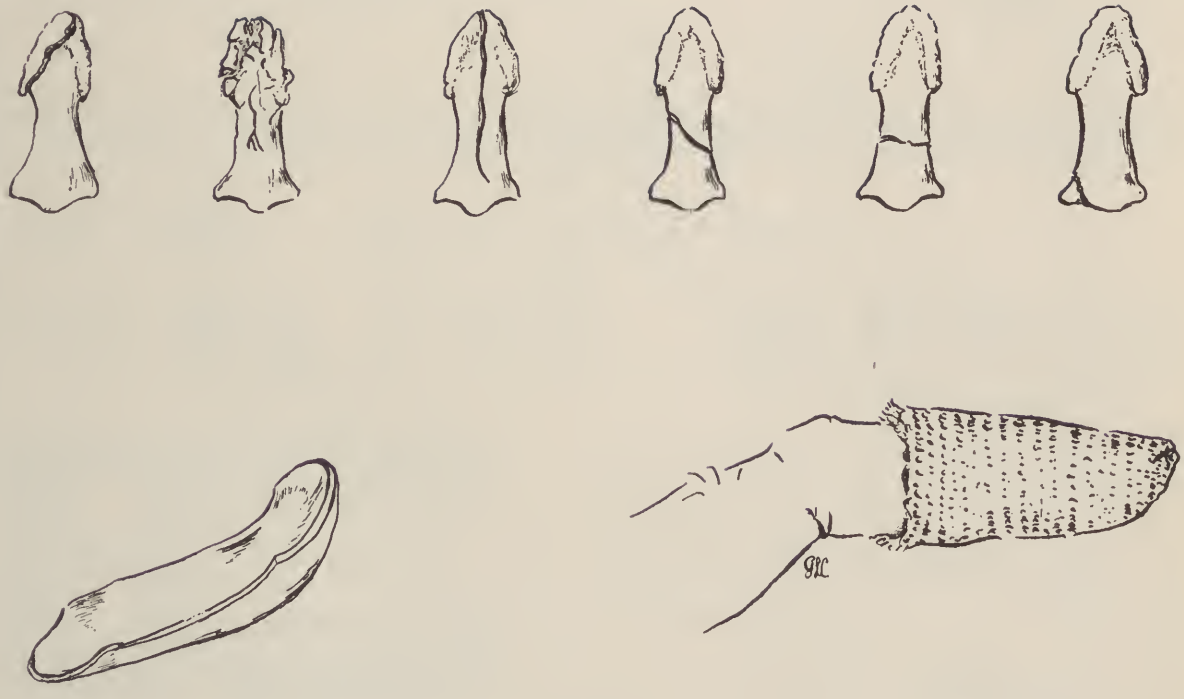


Fig. 2

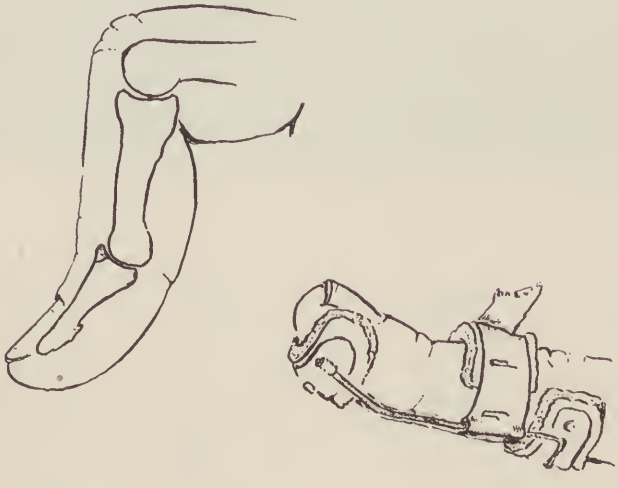
Non-displaced fractures of the distal phalanx can be immobilized by a gutter splint or tube gauze saturated with collodion. Slight flexion of the joint during immobilization is desirable. Union can take up to one year in some situations, and non-unions are unusual; but when they do occur, treatment is often unnecessary. Duration of the acute treatment is three to five weeks.

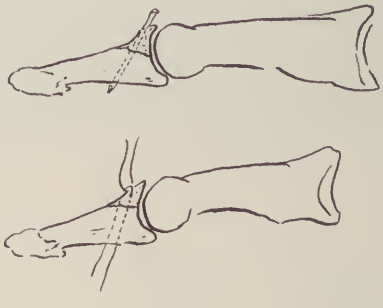


A



B





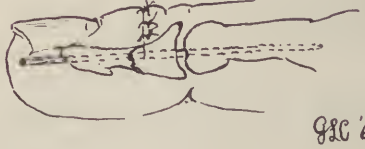


C



D





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Fig. 3

A. A small flake of bone avulsed with the extensor tendon. The treatment is satisfactorily carried out by hyperextension of the distal phalanx either in plaster or with a spring metal splint. Plaster treatment requires that the proximal interphalangeal joint be flexed to 90 degrees, and the plaster should be applied directly over tube gauze. The hazard in this form of therapy is stiff IP joints, and plaster immobilization should not be extended beyond four weeks. B. A large bone fragment with subluxation of the joint surfaces is best treated by a pull-out wire or a small K-wire. C. Flexor tendon avulsions with a fragment of bone are treated by internal fixation. D. Compound fractures need stabilization with an internal pin. The fingernail also adds strength to the fixation and should be preserved if possible. Usual irrigation and debridement of the wound is mandatory.

REFERENCES

1. Howard, L. D., Jr.: *Fractures of the Small Bones of the Hand.* San Francisco, California.
2. Flatt, A. E.: *The Care of Minor Hand Injuries.* St. Louis; C. V. Mosby Company, 1963.

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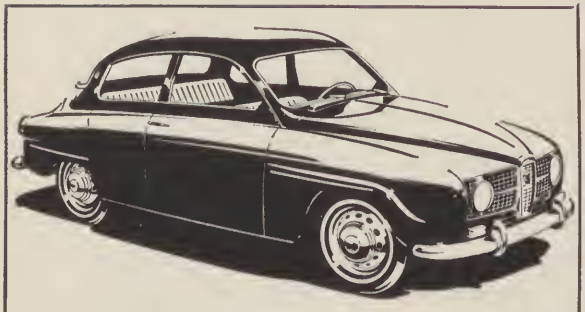
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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Some Social Factors in Rehabilitation

> ***The clinical picture is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes, and fears.***—Francis Peabody

The clinician can no longer practice in isolation. He is part of a constellation of health services which consume a large proportion of national wealth and engross an increasing number of lay and paramedical workers. These services have grown like Topsy, often poorly organized and integrated and difficult to use effectively because of cross purposes and poor definition of their role.

The physician needs many or most of these growing health facilities to give good medical care. An increasing load of administrative and paper work is required to obtain them. In the management and rehabilitation of patients with long term impairments, a knowledge of social factors is necessary for a full understanding of the patient in his environment.

If the physician is to use the many available health services in his community, the first step is to identify the social needs of each patient. If this is done early, it is frequently possible to foresee and prevent later medical complications.

A system of investigating and identifying the social needs of patients is given here. It has been helpful as a tool to unearth the specific social problems of individual patients.

Social independence is defined in terms of what the patient contributes to or requires of the community he lives in. Maximal social independence is exemplified by the wage earner who is able to support his family, pay taxes, and participate in community activities. A lesser degree of social independence is represented by the person who must be helped in some way by an outside agency or his family, either financially, in activities of daily living, or vocationally. People who require charitable or government support have the least social independence. Social factors in illness are grouped under home, personnel available for home care, finance, and vocation. Each of these areas is divided into four grades as shown in the accompanying figure.

A number of interesting factors emerged in this study. For example, under the heading *Home,* the family's evaluation of the status of the patient was found to be an important determinant of whether the patient became socially independent in the home. A man in his 70's, disabled but regarded as the "head of the household," is more apt to be socially independent in the home than a younger man with a lesser degree of impairment but not considered to be the head of the household. In essence, the image and pecking order in the family is extremely important in estimating the degree of social independence.

The number of personnel available and willing to help the patient in the home is another impor-

tant element in social independence. The most dependable relatives are the spouse, the parent, unmarried siblings, and unmarried children. If none of these relatives is available, it is likely that some community resource will be necessary to care for the patient.

INVENTORY OF SOCIAL RESOURCES

I. Home

1. **Good:** Patient, spouse, or parent lives in an established home or may be presumed to be "head of household."
2. **Fair:** Patient lives with relatives (married children, married siblings, other relatives).
3. **Possible:** Home arrangements uncertain, unknown, or other than 1 or 2.
4. No home arrangements available.

II. Personnel Available for Home Care

1. **Good:** A responsible adult (spouse, parent, unmarried siblings, or unmarried children) available and willing to aid the patient in daily activities at home.
2. **Fair:** An adult as above but more distantly related (married siblings or married children; other relatives or close companion).
3. **Possible:** Personnel availability uncertain or unknown.
4. No personnel available to aid patient.

III. Financial

1. **Good:** Patient is financially independent of community or distant relatives. If income is from patient's pension, social security, savings, or immediate family, regardless of patient's physical ability, it must be adequate regardless of patient's physical disability.
2. **Fair:** Patient provides some income, but adequate income is dependent on married siblings or children or more distant relatives.
3. **Possible:** Unknown financial resources.
4. No financial resources.

IV. Vocational

1. **No Vocational Disability:** Has definite specific job to return to.
2. **Probable Vocational Disability:** Uncertain job opening.
3. **Definite Vocational Disability:** No job prospect.
4. **Does not apply:** Retired, has never worked (housewife, student) or has been unemployed for a prolonged period.

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DUODENAL ILEUS

With Reference to Superior Mesenteric Artery Compression

JOHN B. HEARN, MB, BS, FFR

THE DIAGNOSIS OF DUODENAL ILEUS is almost invariably first suggested by the diagnostic radiologist as a result of his findings during the gastrointestinal examination of a patient. This finding is almost always unexpected, and when it is suggested that the ileus is secondary to superior mesenteric artery compression (SMAC), the referring physician may be unwilling to accept this as a cause of the patient's symptoms. The radiologist is describing a finding in which the duodenum is markedly dilated, with delay in transit of bowel contents through the dilated duodenum. If the dilatation is sharply limited at the level of the third part of the duodenum (the expected anatomic site of extrinsic pressure from superior mesenteric vessels) and is accompanied by vigorous "to and fro" peristalsis in the dilated segment of duodenum, the possibility of SMAC will be raised.

Before a diagnosis of SMAC can be accepted, other causes of duodenal ileus (a dilated duodenum) must be considered.

CAUSES OF DUODENAL ILEUS

1. Paralytic or adynamic ileus secondary to inflammatory disease, such as duodenal ulcer, cholecystitis, and pancreatitis.
2. Neuromuscular disorders, such as postvagotomy state, vitamin B deficiency, and porphyria.
3. Aganglionic segment, known as megaduodenum.
4. Collagenous diseases, such as scleroderma and dermatomyositis.
5. Occlusion secondary to extrinsic pressure.
   (a) Superior mesenteric artery compression (SMAC).
   (b) Adhesive bands and acute angulation of ligament of Treitz.
   (c) Edema of mesenteric root of small bowel secondary to inflammatory disease.
   (d) Extrinsic pressure from adjacent masses (inflammatory or neoplastic).
6. Intrinsic narrowing of duodenum from congenital stenosis, tumor, or acquired disease.

In the past one and a half years at the University of Maryland Hospital, five cases have



Fig. 1

From the Department of Radiology, University of Maryland Hospital, Baltimore

radiologically exhibited the appearances of duodenal ileus. Two of the cases presumed secondary to SMAC have been treated surgically (duodenojejunostomy) and will be described. In a third case, the diagnosis was made during the investigation of malabsorption syndrome, but in the absence of symptoms attributable to SMAC, it was not operated upon. The fourth and fifth cases were cases of duodenal ileus secondary to duodenal ulcer and regional ileitis, respectively.

A sixth case, which I investigated in Coventry, Great Britain, involved a young man immobilized in plaster after an automobile accident. Shortly afterward he developed severe vomiting due to SMAC and was cured by duodenojejunostomy.

The first two cases mentioned represent typical examples of this condition.

Case 1.—A housewife, age 36, was admitted with the complaint of a lump in the upper part of her abdomen for two months. She complained that her "stomach felt full and that food could not get out." This symptom was worse after eating and when she stood erect; it was eased by lying down. Physical findings were normal. An upper gastrointestinal series showed the esophagus and stomach to be normal. The duodenal cap was normal, but there was marked distention of the first and second parts of the duodenum with vigorous "to and fro" peristalsis. An area of extrinsic pressure was seen at the junction of second and third portions of the duodenum. The extrinsic defect was seen to be vertical in direction and was considered to be secondary to SMAC (Fig. 1). It was noted that the obstruction was relieved to a large extent when the patient lay down. A cine study was performed which demonstrated in dynamic form the partial obstruction. The patient was sent home with conservative treatment recommended, but symptoms persisted and a month later a laparotomy was performed.

Numerous adhesions were found between stomach, duodenum, anterior abdominal wall, liver, and hepatic flexure from previous abdominal surgery for appendectomy and cholecystectomy. The duodenum was markedly dilated and, after incision of transverse mesocolon, was reported to be secondary to compression by the superior mesenteric artery. A duodenojejunostomy was performed. At the time, a finger passed distally through the area of extrinsic pressure revealed the weight of the superior mesenteric artery compression. No duodenal biopsy was taken. The patient made an uneventful recovery and, to date (six months later), has not had any return of symptoms.

Case 2.—The patient was a housewife, age 31. Abdominal pain and fullness began two years ago and was associated with nausea.

This was relieved somewhat by eructation and antacids. Sometimes her abdomen felt definitely distended. After diagnosis of SMAC by gastrointestinal series, the patient was advised to lie prone after meals. This eased her symptoms.

GI Series: Extrinsic pressure was demonstrated at the third portion of the duodenum (as in Case 1) causing partial obstruction with "to and fro" peristalsis, the obstruction being less severe in prone position (Fig. 2a).

Surgery: Extrinsic pressure from superior mesenteric vessels was demonstrated, and a duodenojejunostomy was performed. The patient is now free of symptoms. A GI series after operation showed barium passing through both the distal duodenum and the jejunostomy. The degree of proximal duodenal distention was much less (Fig. 2b).

DISCUSSION

Since Rokitansky[1] first described the possible etiologic cause of SMAC as a mechanism for producing intermittent duodenal obstruction, authors have published cases or series of cases purporting to be examples of this condition. Proponents of the syndrome of SMAC generally believe that the third part of the duodenum is potentially liable to be squeezed between the aorta and the overlying superior mesenteric vessels, in view of their close anatomic relationship and the acute angle that may exist between the superior mesenteric artery and the aorta. This angle may be expected to become more acute in the presence of visceroptosis, whether natural or acquired due to weight loss, in low attachment of the mesentery of the small bowel, or in high fixation of the ligament of Treitz.

The first cause is the most common theory, and mention is made of the association of hyposthenic build, visceroptosis in young women, and history of weight loss.

In more recent years, many authors have cast serious doubt on the validity of such a diagnosis. They considered that in most cases the dilated



Fig. 2a



Fig. 2b

duodenum can be attributed to one of the other causes listed, and in the presence of a dilated duodenum, extrinsic pressure from the close relationship of the superior mesenteric vessels is to be expected; but it should not follow that the vessels themselves are the cause of the extrinsic pressure. Frequent reference is made to the fact that the patients are often young unmarried women of hyposthenic build who may exhibit manifestations of psychosomatic disorders. It is suggested that a disservice may be rendered both to the referring physician and to the patient in such cases where a "respectable" organic disease such as SMAC is mistakenly identified as the cause of the illness.

This healthy doubt on the honorable status of SMAC has sharpened the awareness of the radiologist and the referring physician of the other possible causes of a dilated duodenum. Some of the causes, such as reflex ileus secondary to duodenal ulcer, cholecystitis, and pancreatitis, should reveal themselves in the clinical history and in the interpretation of the upper GI series. Extrinsic pressure, the result of adjacent tumor, adhesive bands, or neighboring disease, may only be proved at laparotomy; but the presence of coexisting disease is often known and can, therefore, be inferred as a possible cause.

The existence of megaduodenum as a possible but apparently rare cause of a dilated duodenum must be borne in mind, particularly as the aganglionic, and therefore narrowed segment, is often described as being in the distal third of the duodenum. The relative infrequence may in part be due to lack of biopsy material, and it may be that megaduodenum is more common than hitherto realized. This condition is analogous to Hirschsprung's disease and possibly also to achalasia of the esophagus. As might be expected, there is considerable duodenal dilatation with, in the early stages, "to and fro" peristalsis in the proximal segment. It is only by duodenal biopsy that the presence of this condition can be diagnosed; in retrospect, it would have been of interest to have obtained such biopsies in the two described cases.

There still remains a hard core of cases that do appear to fall within the category that can be described as dodenal ileus secondary to SMAC. These patients are not all unmarried women, nor have they unstable inadequate personalities. They may sometimes present as a surgical emergency with subacute obstruction requiring operative re-

lief, as in the case experienced in Coventry. In this case and the two described cases, the relief after surgery was immediate and permanent.

Medical treatment consists of advice on posture; for example to adopt the prone position after meals or to sleep with the foot of the bed elevated. A further measure may be the wearing of corsets by visceroptic patients.

Surgical treatment is almost always effected by the duodenojejunostomy. This causes prompt relief in most patients. It can be questioned whether some of these patients would not have responded as well to a simple laparotomy; however, as in the second case, there is often described radiologic proof of relief of the obstruction after the operation. Some workers prefer lysis of the ligament of Treitz, which relieves the pull of the third part of the duodenum against the vessels and has been favorably reported as being a more benign and equally effective procedure.

Most authorities accept the possibility that some cases of duodenal ileus may be the result of superior mesenteric artery compression and, although advice on posture has uncertain results, operative surgery is often effective in curing these cases. Every effort should be made to exclude all other possible causes; in particular, it would seem that duodenal biopsy could be performed at the time of surgery to provide more knowledge of the possible incidence of aganglionosis of the duodenum.

REFERENCE

1. Rokitansky, C.: *Lehrbuch der Pathologischen Anatomic.* Wien, Baunmuller, 1861, p. 187.

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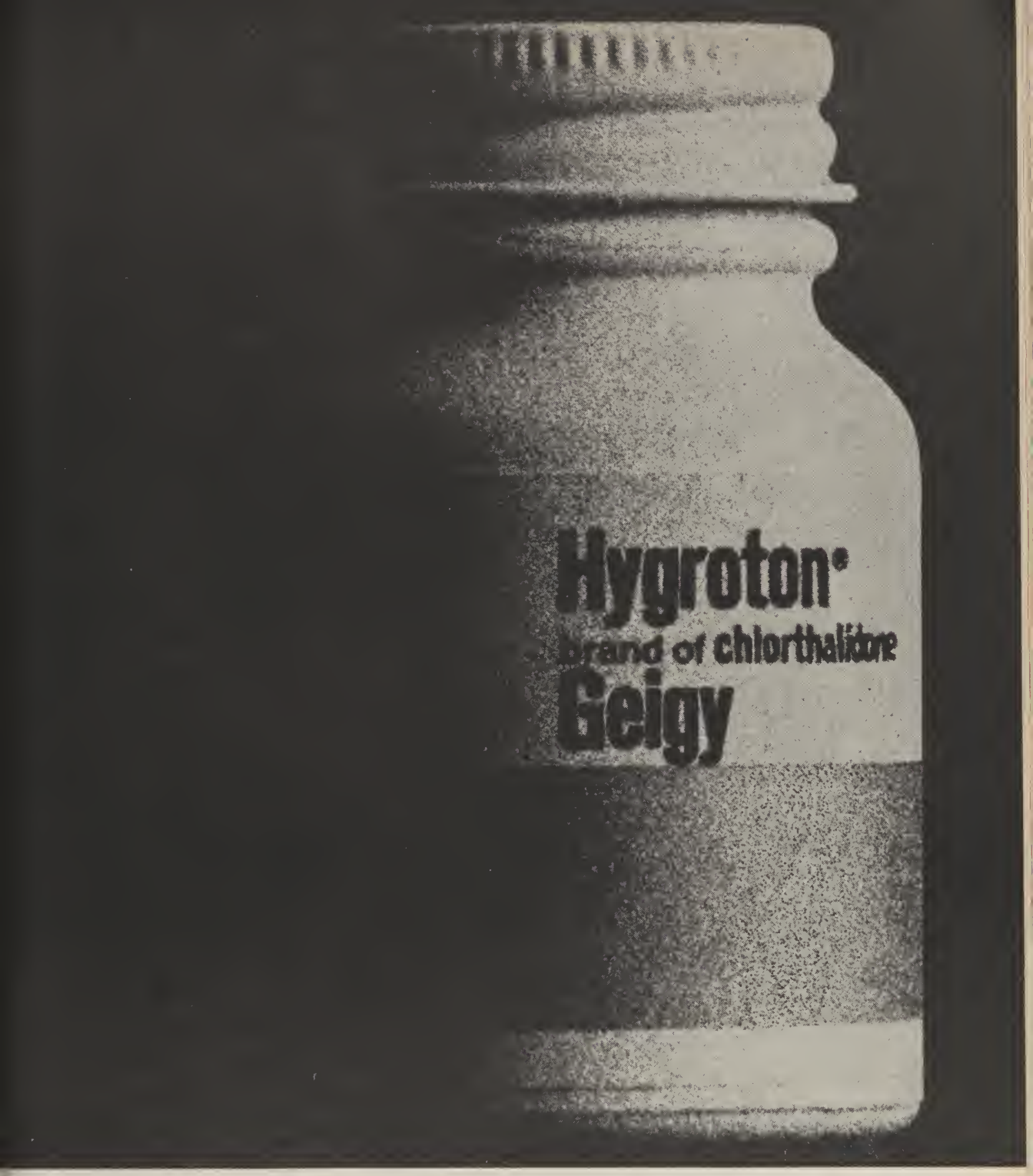
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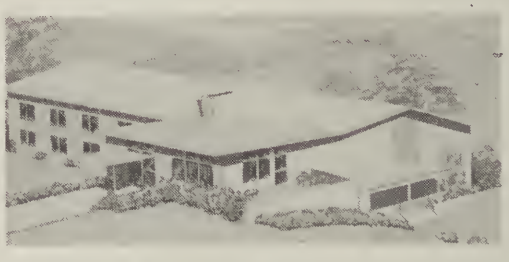
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An Interim Report on the *Community Organization for Health Improvement* Project of the Maryland Tuberculosis Association

NAOMI H. EVANS, MSW, ACSW
Project Director
and
SHELLEY L. MURPHY
Director of Public Information
Maryland Tuberculosis Association

In spite of improved detection and treatment of tuberculosis and in spite of community health education programs, it became clear in 1962 that the number of cases of TB was again rising in Baltimore and some other large cities. To the Board of Directors of the Maryland Tuberculosis Association, the increase seemed to indicate that the efforts of its own staff needed to be expanded and that an expanded program should employ the most recently developed community organization techniques.

The so-called "special project" was established by the Maryland Tuberculosis Association in the fall of 1962. Those concerned with putting this project into motion were charged with giving the necessary incentive to and obtaining the necessary cooperation from the citizens, physicians, and health and welfare agencies in the appropriate area in order to obtain an all-out effort to eliminate tuberculosis from that district. Because it was expected that the special project would be a prototype for succeeding ventures, a relatively small, easily defined neighborhood was selected in which tuberculosis and other respiratory diseases remained a significant public health problem. The area chosen had and has the highest incidence of tuberculosis in Baltimore. In one census tract the 1962 case rate was 393.2 compared to a city-wide rate of 77.8 and a national rate of 29.4. The area abuts the Druid Health Center at North Avenue and Pennsylvania Avenue and is known to urban renewalists as "Mt. Royal-Fremont." This densely populated area contains 925 acres of deteriorating housing. The population is about 64,000, most of whom are in the lower socio-economic group, and 95% are non-white. Forty per cent of the population are under the age of 15, and the median family income is under $3,000.

If the physical environment can be described as poor—and it can—then the sociological characteristics are more so. The population is highly mobile. Family life is matriarchal with alarming numbers of unplanned and unwanted babies. Tuberculosis and VD rates are high, as is the infant mortality rate; and most of the other classic social problems are prevalent. In spite of these dismal facts, the community has several real strengths, among them being some well-endowed and articulate citizens and seven established churches.

Since the beginning the program has concentrated on:

1. What needs to be done to better serve similar urban communities.

2. What methods are used by the agencies working in the area in the course of their regular work.

3. What modifications or additions are necessary to enable the TB Association and the Health Department to reach and effectively aid such communities.

It became apparent that we would have to develop a multifaceted health program. A professional advisory council was organized with representation from most of the health, education, and social welfare agencies already operating in the area. Its purpose has been to provide a forum for the airing of shared problems, to serve as a clearing house for information on individual agencies' efforts in the project area, and to provide guidance for the TB Association as it moved forward with its health program. Among its projects, the professional advisory committee has assisted in the planning and coordination of a one day health-affairs workshop for neighborhood leaders. The advisory committee also provides regular information for a monthly newsletter to the community and was instrumental in securing a study of attitudes toward health and nutrition recently completed by the City Health Department in cooperation with the Maryland TB Association.

Currently the professional committee is investigating ways to assist the elderly, single residents of the Murphy Homes housing project to meet their unique nutritional problems and needs. In helping to reveal both the shortcomings and the strengths of the various agencies programs and in providing guidance, the advisory committee has rendered invaluable service.

During the second year of the project, certain clinic hours were reviewed and consequently may be revised. Recognizing the need for enlisting the support of the people the program was designed to serve, we established a representative citizens health committee. Composed of key people in the project area, it includes representatives of every social and economic class, representatives of neighborhood and block organizations, and churches. The primary task of this group has been to create an awareness of health problems and an appreciation of the services available in the community for coping with them. Members of the leadership group routinely participate in the planning of health programs for their area, based upon their own identification and expressed needs. Because the patient with tuberculosis often suffers no acute pain in the early stages, it is difficult for many to recognize this disease as a personal or public health problem. We therefore found it necessary to couple our tuberculosis information with some health aspects which were more easily identifiable by the families in the project community.

To this end we have conducted special programs, including one for youth dealing with sex education, VD, and family planning. A one-day workshop was conducted by leaders in family planning, tuberculosis, mental health, alcoholism, maternal and child health, and geriatrics. One immediate result of this workshop is establishment of a rodent control program in the area.

As we have worked in the area, conducting programs such as those described and monthly health forums and local block and church meetings, we have assessed the community's inability to fully utilize the available health services. We found that most of the residents were unfamiliar with health resources and thus neglected their physical well being. We found that necessity to earn one's daily bread usually took precedence over maintaining one's health. We were told that there was a lack of confidence in hospitals, doctors, and clinics, seemingly the result of unfortunate experiences in the use of these facilities. Engendered by and perhaps engendering poverty, there is in the area a sense of resignation and fatalism, apathy, and inaction toward health problems. There is strong concern with the present but little desire or effort to plan for the future.

It is now apparent that in order to promote a broad health program, a realistic evaluation of the present programs must be made. There is a serious lack of health education, and efforts must be made to remedy this defect. Health education methods currently in use have not reached this community effectively. Thought must be given to utilizing the citizens' concern with their immediate aches and pains as a starting point for longer range health education. That this method of reaching the hard to reach is not being used, was pointed up in the following responses to a survey questionnaire:

> The red tape . . . it takes so long and they ask so many questions about how, and when, and why . . . why you didn't come before . . . it just isn't worth all that trouble.
> The hospital emergency room won't take you when

you feel sick. And next week, when you feel better, you don't come back for your appointment.
Why isn't that clinic open at night? We work days.
They (the agencies) do their best to keep you from coming back. (This related to a clerk's attitude.)
We need someone to tell us where to turn.

While we are all bemoaning the fact that these people are hard to reach, perhaps we need to look at ourselves through their eyes and see if we are also hard to reach.

The need is urgent for a concerted program that will educate and motivate the reluctant and uninformed toward seeking the help they need. They must be directed toward the sources of help and offered support and encouragement. Further, we must coordinate the efforts of the various agencies interested in health and establish effective communication with knowledgeable individuals and groups servicing the areas we wish to serve.

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Ewing's Sarcoma. — Patients with a presumptive radiographic diagnosis of a malignant bone tumor are needed. It is desired that such patients be referred before establishment of the diagnosis by biopsy in order that they may be admitted for biopsy and immediate institution of therapy.

Metastatic Lung Tumors. — Referrals of patients with well-defined, measurable bilateral lung metastases (from any primary site) are needed for radiation therapy studies.

Physicians interested in having their patients considered for any of these studies may write or telephone Ralph E. Johnson, MD, Clinical Center, Room B1B-41A, National Institutes of Health, Bethesda, Md. 20014, Telephone: 656-4000, Ext 65457 (Area Code 301).

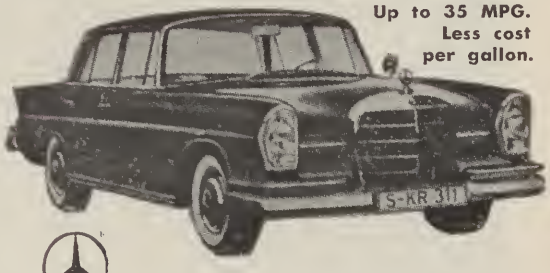
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Towson Cooperative Nursery for Retarded Children

The Towson Cooperative Nursery for retarded children, like most social and educational groups, burst into being as a result of an overwhelming and fundamental necessity, grew at first haltingly, nurtured mainly by the vision, energy, and compelling needs of the parents of trainable retarded children. For these children, no less deserving than others, their only real hope is an enlightened, understanding parent; and for these parents, their only hope is themselves. True, there are limited agencies for guidance as there are educational facilities, but for the preschool trainable retardate, at this most crucial period, the only salvation seems to lie in the cooperative efforts of the parents, under the direction of professionally trained personnel.

The Towson Cooperative Nursery for retarded children is dedicated to these principles. Parents from every section of the greater Baltimore area have found, since 1961, a source of education both for themselves and their children, mutual understanding of problems beyond the comprehension of those not personally affected by mental retardation, inspiration, security, and satisfaction.

Through the natural but laborious process of evaluation, reevaluation, refinement, and sophistication, the present organization was attained. The typical parliamentary hierarchy is established: chairman, secretary, and treasurer, supported by dynamically involved parents.

Constitutional requirements include such primary premises as parent participation in classroom activities, written class observations, attendance at monthly business meetings, representation at all meetings of the Maryland Association for Retarded Children with reports made to the general membership, and family membership in the Baltimore chapter of the MARC.

The constitution further establishes that there be a principal, teachers, and assistant teachers, in proportion to the number of children, who must meet educational and experiential standards as determined by the Maryland State Department of Education.

Another constitutional dictum is that a board of advisors shall at all times exist with power to contemplate all matters of policy, educational technology, psychological methodology, etc., as deemed necessary. Some of the most outstanding minds in various fields, including medical, legal, psychological, educational, religious, and social, have agreed to give unlimited assistance and cooperation. The permanent members are: Mrs. Thomas Gordon, *Baltimore Chapter, MARC;* Hans J. Koetter, MD, *physician;* H. Emslie Parks, *attorney;* Lewis F. Ransom, *minister;* Betty C. Reid, *special education;* and Roger E. Saunders, *clinical psychologist.*

The principal is H. Gordon Thomas, who holds bachelor and master degrees. The teacher is Florence Dunlop, who holds a bachelor degree, and the assistant teacher is Elinor Baker, who has five years experience with the preschool mentally retarded and has taken extensive courses at local universities.

The school year is concurrent with that of the Baltimore County school system. The nursery operates three days a week, Tuesday, Wednesday, and Thursday, from 9:45 until 12 noon. Because of our organization, staff, and the excellent facilities provided through the courtesy of the Towson Methodist Church, we are licensed by the Baltimore County Department of Health and recog-

nized by the State Department of Education and the State Department of Mental Health. We are individually members of the Baltimore Chapter, Maryland Association For Retarded Children, and the principal is a member of the American Association on Mental Deficiency.

The constitution and bylaws provide that all children, regardless of race, creed, or national origin, be accepted if they meet the basic requirements as to physical condition, mental retardation, and family cooperation. Each applicant must provide a medical, social, and developmental history, have a home visitation by the chairman and director of parent education, provide evidence of the required reading, and place the child in the nursery with parent or parents for two days of observation. The mother must complete one month probationary period, three weeks of which she is not allowed in the classroom; the fourth week she is a participating mother. After the probationary period, the mother must complete three weeks of written observations. At this point the executive and admissions boards review all data and determine if nursery placement will be of significant value to the child and the family.

Our most critical consideration is what the experience means to the child. To identify each hope would be an endless task, but to generalize is to oversimplify. Perhaps the fairest statements would be that we as parents of retarded children want our children to be as self-sufficient as their individual limitations allow in all areas of socialization, or the maximum development of the individual to the degree that his particular capacities permit.

The Towson Cooperative Nursery does not attempt to duplicate facilities or efforts but rather offers a unique program dedicated only to the specific needs of the preschool mentally retarded child and his family.

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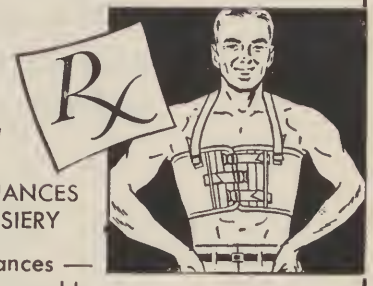
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1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

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SUMMARY OF 1964 SANITARY SERVICES

Environmental Hygiene. — The Division of Community Sanitation investigated 2,850 complaints involving sanitary problems. More than 2,300 routine sanitary inspections were made, including inspections of foster homes, day nurseries, convalescent homes, and swimming pools. Water samples were collected at 1,440 locations. The Division of Rodent Control employed environmental control techniques in the servicing of 3,485 complaints of rodent infestation. Special surveys were conducted in 33 blocks, and 90 rat bites were investigated. More than 11,900 inspections were made in the rodent control program. Educational activities in rodent control included distribution of leaflets, talks to civic groups, and training of employees of other city agencies in rodent control techniques.

Milk Control.—The Bureau of Milk Control's daily phosphatase tests of milk samples revealed no instance of improper pasteurization for the ninth consecutive year. About 2,000 dairy farms licensed to produce milk for Baltimore consumers were inspected by the bureau at least twice during the year. Milk samples from each farm were tested for quality and purity by the Baltimore City Health Department laboratories. In addition, the milk industry sampled each dairy farm monthly and conducted more than 50,000 supplementary tests. A noteworthy event of the year was the discovery and control of the pesticide heptachlor in Baltimore's milk supply. This was accomplished through the cooperation of the milk industry with all levels of government agencies.

Food Control.—The Bureau of Food Control removed from trade channels and destroyed more than 34,000 pounds of food. Eighteen food dealers were fined by the courts for violation of food and health laws. Investigations were made of 20 group illnesses alleged to have been caused by food as well as single reported cases of hepatitis, salmonellae, and dysentery. During the 1964 strike of chain food store employees, no untoward public health incident occurred, thanks to constant liaison and cooperation between the bureau and the management of both independent and chain organizations.

Industrial Hygiene.—The Bureau of Industrial Hygiene reported a decline in occupational disease cases from 94 in 1963 to 85 in 1964. Inspections were made of 1,035 plants involving 104,505 workers, and 1,024 plans for new buildings or combustion equipment were studied with 375 plant improvements effected. Seventy-two studies were made of potentially harmful conditions in industrial plants, and corrections were made where indicated. In addition to the continuing program of radiation determinations in air, water, and sewage, 50 local radioisotope users were checked by the bureau. Of the 505 air pollution complaints checked by bureau sanitarians, 350 concerned smoke and fly ash. Early in 1964 a Metropolitan Oxidant Network was established in cooperation with the Maryland State Department of Health and the county health departments of Baltimore, Anne Arundel, and Howard counties. Equipment for six stations in the city and surrounding counties was supplied by the State Department of Health, while the city's Bureau of Industrial Hygiene provided supervision and maintenance.

Meat Inspection.—The Bureau of Meat Inspection made more than 30,000 inspections of city and county slaughtering and meat processing

plants supervising the slaughtering of 204,000 animals and the processing of over 27,000,000 pounds of meat and meat products. Bureau veterinarians condemned 358 animals and 23,000 parts of animals for having various diseases, and 8,357 pounds of meat products were condemned as unfit for human consumption.

Sanitary services of the Baltimore City Health Department are under the direction of Mr. George W. Schucker.

Robert E. Farber, MD
Commissioner of Health



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Highlights

MEDICAL EDUCATION DIRECTOR

Frederick J. Heldrich, Jr., MD, has been named director of continuing medical education for the Department, serving on a part-time basis. The need for a physician to direct and coordinate programs of postgraduate education for physicians in various sections of the state has been established by a joint committee on medical education composed of representatives from the University of Maryland and the Johns Hopkins University medical schools, the Medical and Chirurgical Faculty, the Maryland Hospital Council, and the Health Department. The committee, who have been considering the problem for some time, will serve in an advisory capacity. Funds for the endeavor became available through the Expanded Plan for Health Services for Children.

Dr. Heldrich, a pediatrician practicing in Frederick, has academic positions in the Department of Pediatrics of both the University of Maryland and the Johns Hopkins University medical schools. He has been associated closely with the medical education program of the Frederick Memorial Hospital and is acutely aware of the importance of postgraduate education programs for physicians.

PROJECT "HEAD-START" FOR PRESCHOOL CHILDREN

Edward Davens, MD, deputy commissioner, has been appointed to a national planning committee which is advising Mr. Sargent Shriver on a new program aimed at improving opportunities for normal growth and development of very young children of the poor. The unique aspect of the program will be the blending and incorporation of health and medical services, social welfare services, and preschool education into a single developmental center, with concerted efforts to involve the parents.

The principal objectives of the program will include:

1. Improving the child's physical health and physical abilities.
2. Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline.
3. Improving the child's mental processes and skills with particular attention to conceptual and verbal skills.
4. Establishing patterns and expectations of success for the child which will create a climate of confidence for his future learning efforts.

Mrs. Lyndon B. Johnson is chairman of a national advisory committee to the program. The first phase will be directed toward a summer project of eight weeks for about 100,000 children who are scheduled to enter the first grade in the fall.

"WATER IN MARYLAND" DISTRIBUTED

Water in Maryland, a 36-page publication, has been prepared by the Office of Public Health Education in cooperation with the Bureau of Environmental Hygiene. The mimeographed booklet is being distributed to teachers, upon request, to aid them in incorporating into their classroom instruction information about water pollution control, especially as it relates to Maryland. It may be useful also to community groups concerned about clean water.



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STATE OF MARYLAND

Department of Mental Hygiene

PROBLEMS OF THE RURAL COUNTIES

A STATIONARY OR DECLINING population; a substantial proportion of older people; a lack of employment opportunities which causes a continuing out-migration of younger residents; an unmet need for professional psychiatric personnel; a sparsity of community mental health facilities so that the state mental hospital often provides the only available treatment service for broad population segments—these are some of the facts that characterize the rural counties.

The 1960 census report indicated that the number of Maryland residents had increased 150% since 1910. During this 50-year period, five of the state's 23 counties reported a population rise of less than 10%. Three other counties declined in population, one by more than 25%. Seven of these eight counties are on the Eastern Shore, while one is in the far western part of the state.

According to current population estimates, 5.1% of the state's total population live in these counties. However, 7.5% of the patients in the six state-operated psychiatric hospitals were reported as residents of this area. Each of these counties had a patient rate at least one-third larger than the comparable rate for the entire state. Patient movement data from all mental health facilities serving Maryland residents are available from the Psychiatric Case Register. Latest published statistics (for the 1963 fiscal year) indicate that while 6.4% of all admissions to state hospitals were residents of these counties, only 3.7% of admissions to other treatment facilities were from this area.

The Eastern Shore State Hospital at Cambridge is responsible for the inpatient care of the mentally ill in the eight-county area of Maryland's Eastern Shore. In recent years, its staff has worked closely with hospitals, clinics, and other community resources in the development of local mental health services. In this it has served as a catalyst for the growth of a coordinated program whose impact is just beginning to be felt.

The problems of Maryland's rural counties has its counterpart in every section of the United States. It should be clear that the factors underlying their mental health problems and needs are interrelated with other basic issues and can only be resolved through a coordinated endeavor. Prime consideration must be given to programs for minimizing the problems of low income, continuing population drain, and a deficiency of professionally trained personnel.

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Construction of the Greater Baltimore Medical Center near Towson is proceeding rapidly. Intensive study and planning will be evidenced by the many innovations not only in the building construction but also in the basic design and the organizational plan.

The building initially will house 400 beds, but the plans permit later expansion to a 50% greater capacity. The design of the nursing units represents a new concept of unusual efficiency. Instead of the usual long corridors between two rows of rooms, patient rooms at the GBMC have been grouped into units of eight rooms each, with separate foyers, nurse stations, and all supplies and equipment for each unit close at hand. Thus the nurses will be closer to their patients at all times,

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and both service and supplies will be more quickly available to the patient. In one wing which preserves the traditional corridor design, there will be a central corridor for medical and service personnel and a separate corridor for visitors.

In the Greater Baltimore Medical Center 90% of all adult rooms will be private, and the nursing unit design will eliminate traffic past the doors. In the rooms themselves, all items of equipment including oxygen, suction, hot and cold running water, communications systems, and electrical controls of most conveniences will be of built-in design and readily accessible to patient or nurse.

Highest standards of construction were assured by careful selection of the participating contractors. General building contractor for the project is Consolidated Engineering Company, Inc., 20 East Franklin St, Baltimore. Structural steel was furnished by Van Rensselaer P. Saxe, 1701 St. Paul St, Baltimore, and by Belmont Iron Works, Eddystone, Pa. The Baltimore Rigging Co., Huntingdon Ave and 25th St, was responsible for the excavation and backfill. Plumbing was installed by Lloyd E. Mitchell, Inc., 4650 Reisterstown Rd; and Murray-Jason, Inc., 1033 South 53rd St, Philadelphia, installed the food service equipment. Elevators are by General Elevator Co., 1115 East 30th St, Baltimore. E. Bruce Baetjer, of Owings Mills, is the landscape architect. These and other contractors are creating a truly outstanding facility.

Personnel organization of the GBMC will also feature innovations for greater efficiency. The nursing department has been decentralized and reorganized along functional lines. Each of five clinical areas will be headed by an expert and administratively competent nurse. These areas are maternal and child care; medical and surgical; eye, ear, nose, and throat; special care; and outpatient service. The nurse clinical director of each unit will set the overall objectives for her unit, hire and train personnel, develop procedures, and participate in administration of the unit. All will be coordinated through the office of the director of nursing.

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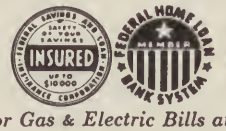
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tages: a larger ratio of nurses to supervisory personnel, shortened lines of communication between nurse and administrator, quicker answers to physicians' problems, and a close physician-nurse-patient relationship.

The architects, Rogers, Taliaferro, Kostritsky, and Lamp and Wilson, Christie, Niles, and Anderson, working in close collaboration with GBMC, have thus planned the hospital with the utmost efficiency of operation and maximum comfort and care of the patient in mind. Formed by merger of Women's Hospital and Presbyterian Hospital, the Greater Baltimore Medical Center is scheduled to be completed by midsummer and in operation by September of this year.

HOSPITAL NOTES

The Hospital Council of Maryland reports that increasing use is being made of Emergency Room outpatient facilities. The following figures for Maryland support the belief that more and more people are using emergency room facilities for non-emergencies.

	1964	*1963*	*Increase Number*	*%*
Emergency Room Visits	606,826	536,357	70,469	13.1
Outpatient Visits	1,811,950	1,698,013	113,013	6.7
Population (July 1)	3,407,400	3,366,750	40,650	1.2

Administrative changes in Maryland hospitals include the following: Mrs. Helen P. Marsellas is the new administrator of Calvert County Hospital, succeeding Vincent J. Rice. F. N. Griffith, former assistant administrator of Presbyterian Eye, Ear and Throat Charity Hospital, is now acting administrator, succeeding Thomas I. Harnish. Francis Richardson succeeds James E. Bangerd as administrator of Miners Hospital, Frostburg.



Louis Krause, MD, Chairman
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Elizabeth Sanford
Librarian

DENTISTRY AND THE LIBRARY

GEORGE M. ANDERSON, DDS

SINCE THE FOUNDING of the first dental school in the world, the Baltimore College of Dental Surgery, in 1840, an increasingly close relationship has developed between medicine and dentistry. It is natural that this would happen, as the early dental educational recommendations by Horace Hayden, MD, to the University of Maryland were based on the hope that dental lectures would be included in the medical curriculum.

Textbooks and professional journals supply the foundation for clinical service. Dental practitioners should know more of medical texts and journals and physicians should be more familiar with dental literature. Certain texts contain information essential to medicine and dentistry. One of the newest texts in this respect is *Oral Histology,* written by D. Vincent Provenza, BS, MS, PhD, published late in 1964 by J. B. Lippincott Co. The author is professor and head of the Department of Histology and Embryology, Baltimore College of Dental Surgery, Dental School, University of Maryland. Collaborators are Harold Fullmer, DDS, principal investigator and dental director, Laboratory of Histology and Pathology, National Institute of Dental Research, Washington, D. C., and Joseph H. Seipp, DDS, MS, instructor, Department of Histology and Embryology, Baltimore College of Dental Surgery, Dental School, University of Maryland, and assistant dental surgeon, The Johns Hopkins Hospital. It is profusely illustrated, including 11 plates (83 subjects) in color.

If refreshment of memory for the histology of the human jaws and teeth is desirable, *Oral Histology* will be found on the shelf of your library. It is recommended reading.

SELECTED LIST OF BOOKS ON DENTISTRY

DENTISTRY

Bernier, Joseph L.: *The management of oral disease,* 2nd ed, Mosby, 1959.

Burket, Lester W.: *Oral medicine: diagnosis and treatment,* 3d ed, Lippincott, 1957.

Gehl, Daniel H.: *Complete denture prosthesis,* 4th ed, Saunders, 1958.

Grossman, Louis I., ed.: *Lippincott's handbook of dental practice,* 3d ed, Lippincott, 1958.

King, John J. D.: *The effect of sugar supplements on dental caries in children,* H. M. Stationery Off., 1955.

Landy, Chester: *Full dentures,* Mosby, 1958.

Swenson, Merrill G.: *Partial dentures,* 2nd ed, Mosby, 1959.

Thoma, Kurt H.: *Oral and dental diagnosis,* 5th ed, Saunders, 1960.

Tiecke, Richard W.: *Pathologic physiology of oral disease,* Mosby, 1959.

Wheeler, Russell C.: *A textbook of dental anatomy and physiology,* 3d ed, Saunders, 1958.

DENTISTRY—HISTORY

McCluggage, Robert W.: *A history of the American Dental Association,* Amer Dent Asso, 1959.

DENTISTRY—HYPNOTISM IN

Erickson, Milton H.: *The practical application of medical and dental hypnosis,* Julian Press, 1961.

Shaw, Samuel I.: *Clinical applications of hypnosis in dentistry,* Saunders, 1958.

DENTISTRY—MILITARY

Jeffcott, George F.: *United States Army Dental Service in World War II,* Off of the Surg General, 1955.

DENTISTRY—PRACTICE

Collins, Leon H.: *Internal medicine in dental practice,* 5th ed, Lea & Febiger, 1960.

DENTISTRY—YEARBOOK

The yearbook of dentistry. 1963-64, Yearbook, 1964.

MOUTH

Laskin, Daniel M.: *Management of oral emergencies,* Thomas, 1964.

Orban, Balint, ed.: *Oral histology and embryology,* Mosby, 1944.

Martin, Hayes E.: *Mouth cancer and the dentist,* Amer Cancer Soc, 1949.

ORAL ROENTGENOGRAPHY

Ennis, LeRoy M.: *Dental roentgenology,* 5th ed, Lea & Febiger, 1959.

Shafer, William G.: *A textbook of oral pathology.* Saunders, 1958.

Stafne, Edward C.: *Oral roentgenographic diagnosis,* 2nd ed, Saunders, 1963.

ORAL SURGERY

Berlove, Ira J.: *Dental-medical emergencies and complications,* Yearbook, 1959.

Clark, Henry B.: *Practical oral surgery.* 2nd ed. Lea & Febiger, 1959.

Ross, James C.: *Essentials of surgery for dental students,* 2nd ed, Livingstone, 1952.

Thoma, Kurt H.: *Oral Surgery,* 3d ed, Mosby, 1958.

ORTHODONTIA

McCoy, James D.: *Applied orthodontics,* 7th ed, Lea & Febiger, 1956.

PERIODONTIA

Goldman, Henry M.: *Periodontal therapy,* 2nd ed, Mosby, 1960.

McCarthy, Philip L.: *Diseases of the oral mucosa,* Blakiston, 1964.

Sorrin, Sidney: *The practice of periodontia,* Blakiston, 1960.

Gt. Brit. U. K. Mission: *Fluoridation of Domestic Water Supplies in North America as a Means of Controlling Dental Caries,* H. M. Stationery Off, 1953.

THERAPEUTICS, DENTAL

Accepted dental remedies, 29th ed, Amer Dent Asso, 1964.

Sutherland, Violette C.: *A synopsis of pharmacology,* Saunders, 1959.

MATERIALS, DENTAL

Kilpatrick, Harold C.: *High speed in dentistry: equipment and procedures,* Saunders, 1959.

Peterson, Shailer A.: *Clinical dental hygiene,* Mosby, 1959.

Schwartz, Jacob R.: *The acrylic plastics in dentistry,* Dental Items of Interest, 1950.

PATHOLOGY, DENTAL

Schwartz, Laszlo: *Disorders of the temporomandibular joint,* Saunders, 1959.

Shafer, William G.: *A textbook of oral pathology,* Saunders, 1958.

Thoma, Kurt H.: *Oral pathology,* 5th ed, Mosby, 1950.

SCHOOLS, DENTAL

American Association of Dental Schools: *Admission requirements of American dental schools. 1964/65,* Amer Asso Dental Schools.

World directory of dental schools, World Health Organization, 1961.

Woman's Auxiliary

MARYLAND WAMCF HYGEIA FILIAE

APRIL, 1965

MRS. IRVING, J. TAYLOR, *Auxiliary Editor*



DON'T FORGET OUR ANNUAL MEETING
APRIL 21 and 22

Ever S. Curtis, MD, will be guest speaker at our Thursday luncheon. Dr. Curtis is a general practitioner in Gloucester, Mass. She is a councilor in the Massachusetts Medical Society and secretary of the Public Relations Committee. She is also a member of the AMA's national speakers bureau—all this in addition to being the mother of five children.

"Notes of Fashion" Luncheon and Fashion Show

THE TENTH ANNUAL LUNCHEON and fashion show sponsored by the Woman's Auxiliary to the Montgomery County Medical Society was held January 25 in the new Regency Ballroom of the Shoreham Hotel in Washington. Seven hundred doctors' wives and guests attended.

Three notable personalities from the music world shared the spotlight with Pauline Trigere's spring collection of designer fashions at this year's "Notes of Fashion" luncheon and style show. Mark Russell, Washington's favorite humorist and pianist, entertained with a politically oriented musical skit. Mr. Russell, who has toured nationally as a nightclub entertainer, is currently appearing in the Shoreham Hotel's Marquee Lounge and on a weekly television program, "Mark Russell's Washington," on WMAL-TV. Dr. Howard Mitchell, conductor of the National Symphony Orchestra, and Patrick Hayes, concert impresario, were honored guests.

Also honored at the head table were: Mrs. George E. Gardner, RN, 1954 recipient of the Woman's Auxiliary nursing scholarship; Dr. H. Palmer Hopkins, director of the Office of Student Aid at the University of Maryland; Mrs. John E. Baybutt, president, Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland; Robert Sweeney, assistant attorney general of Maryland; Congressman Charles McC. Mathias, Jr., Sixth District, Maryland; Mrs. Luther L. Terry, wife of the surgeon general of the United States; Reverend John Brady, chaplain of Holy Cross Hospital, Silver Spring; Mrs.

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Medical Director



Howard Mitchell; Mrs. Patrick Hayes; Ruey S. Messenger, fashion coordinator of Julius Garfinckel and Company, who sponsored the fashion show; Estelle Marr, fashion representative of Pauline Trigere fashions; Mrs. Marvin L. Kolkin, president, Woman's Auxiliary to the Montgomery County Medical Society; and Mrs. Solomon E. Barr, luncheon chairman.

A Weekend at the Waldorf and a box at a National Symphony Orchestra concert topped the list of exciting door prizes. The musical theme was carried out in the handsome styrofoam eighth note centerpieces and in the menu, consisting of medley of fresh fruit overture, concerto for chicken and mushrooms, wild rice a la Katchaturian, string ensemble of beans and almonds, rock and rolls with butter, divertimento of chocolate parfait, and finale of coffee or tea.

The profit from the 1965 "Notes of Fashion" luncheon and style show exceeded $1900. The money will be used for scholarships in the medical, nursing, and allied fields through the University of Maryland and Johns Hopkins University. The Auxiliary is also underwriting two of the scholarships awarded by the Montgomery County TB and Heart Association. This scholarship fund enables interested and capable high school students to spend a summer working in a science-oriented field. Competition for these grants is keen.

The Woman's Auxiliary to the Montgomery County Medical Society sponsored its first scholarship student at the University of Maryland School of Nursing in 1953, after realizing the urgent need for more qualified women in this field. Until the first luncheon and fashion show was held in 1955, various means were used to raise funds for the scholarships. Bake sales and raffles were two of the many ways. Three hundred women attended the first luncheon and paid $3.50 a ticket. The event has been a continuing success, and now more than 700 women can be counted on to support the benefit at $7 a ticket.

After realizing the difficulty involved in selecting and sponsoring a deserving nursing student by ourselves, it was decided in 1961 to allocate the funds to the University of Maryland Office of Student Aid for distribution to the University of Maryland School of Nursing and to the medical students loan fund at the University of Maryland Medical School. In 1964 we disbursed $3,500 in scholarship funds. Approximately $2,200 of this amount was raised at the annual luncheon and fashion show, and the balance represented an accumulation of Auxiliary funds through the years. The money was distributed as follows: $1000 each to the University of Maryland Medical School and to the Johns Hopkins Medical School through AMA-ERF, $750 to the medical students loan fund at the University of Maryland Medical School, and $750 to the University of Maryland Nursing School scholarship fund.

The support that our 180 members (26 of whom joined the Auxiliary this year) have given our annual fund raising event is gratifying and has helped to unify us toward the common goal of establishing community goodwill. This is the main ideal for which our organization was founded 18 years ago.

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Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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THE BALTIMORE ASSOCIATION of Medical Assistants is having a membership drive. A flyer is being circulated to physicians' offices with the following message:

ATTENTION PHYSICIANS

Is your secretary, technician, receptionist, a member of the Baltimore Association of Medical Assistants? The B.A.M.A. is a responsible organization, recognized and approved, by the American Medical Association.

Our Aim—Working toward the improvement of your aide's skills and thus, the better management of your office in general.

The Baltimore Association of Medical Assistants will become more important and more beneficial through an increased membership. We hope you will encourage your office assistants to join the Baltimore Association of Medical Assistants and —Assist the B.A.M.A. in assisting you. Please have your office personnel contact:

Miss Betty Fern, Chairman
Membership Committee
c/o Dr. Harry Kelmenson
2 East Read Street
Baltimore, Maryland, 21202

The Wicomico Association of Medical Assistants meets in Salisbury once a month with a combination dinner and business meeting and a guest speaker. William B. Smith, MD, and John M. Bloxom, MD, are the new advisors to the group in Wicomico County.

The Baltimore Association of Medical Assistants recently visited Philadelphia as the guests of Smith, Kline, and French. The luncheon was attended by a number of Smith, Kline, and French executives who spoke to the group. They were then taken on a tour of the building and saw how the various medications are manufactured. The group also toured the research laboratories. After the tour, coffee was served, and the physician in charge of their clinic spoke to the group and answered questions.

The Maryland Association of Medical Assistants will again sponsor a coffee booth at the annual meeting of the Medical and Chirurgical Faculty, at the Alcazar in Baltimore on April 21, 22 and 23. Be sure to visit the booth, have some coffee, and learn all about this association. MAMA will hold its fifth annual meeting at the Sheraton Belvedere Hotel, Baltimore, on Saturday, April 24, starting at 12:30 PM. The annual banquet and installation of officers will be held that same evening. The master of ceremonies will be William H. Kammer, Jr., MD, advisor to MAMA. The installing officer will be his medical assistant, Mrs. Rita Cobry, the retiring president of MAMA.

If you would like to form a chapter of the MAMA in your county, the officers will be glad to help you. They will visit your county and answer any questions you may ask. By joining a medical assistant's association you may improve yourself through further education. For information write to Mrs. Rita Cobry, president, 4411 Vale Drive, Baltimore, Md. 21236.

If you are interested in attending the educational sessions and banquet at the annual meeting of MAMA, please contact Mrs. Cobry for a program and reservation form.

Dorothy Hartel

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File: Diarrhea

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8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

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References: 1. Handelman, Cathryn C.: Early management of acne, *Pediat. Clin. North America* 8:265, Feb., 1961. 2. McLean, I. E. D.; Graham, K. T., and East, M. O.: The treatment of acne; a trial of "pHisoHex," *Practitioner* 189: 82, July, 1962. 3. Hodges, F. T.: Therapeutic applications of an antiseptic detergent, *GP* 14:86, Nov., 1956. 4. Wexler, Louis: Treatment of acne vulgaris, *Clin. Med.* 70:404, Feb., 1963.

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STATE MEDICAL JOURNAL

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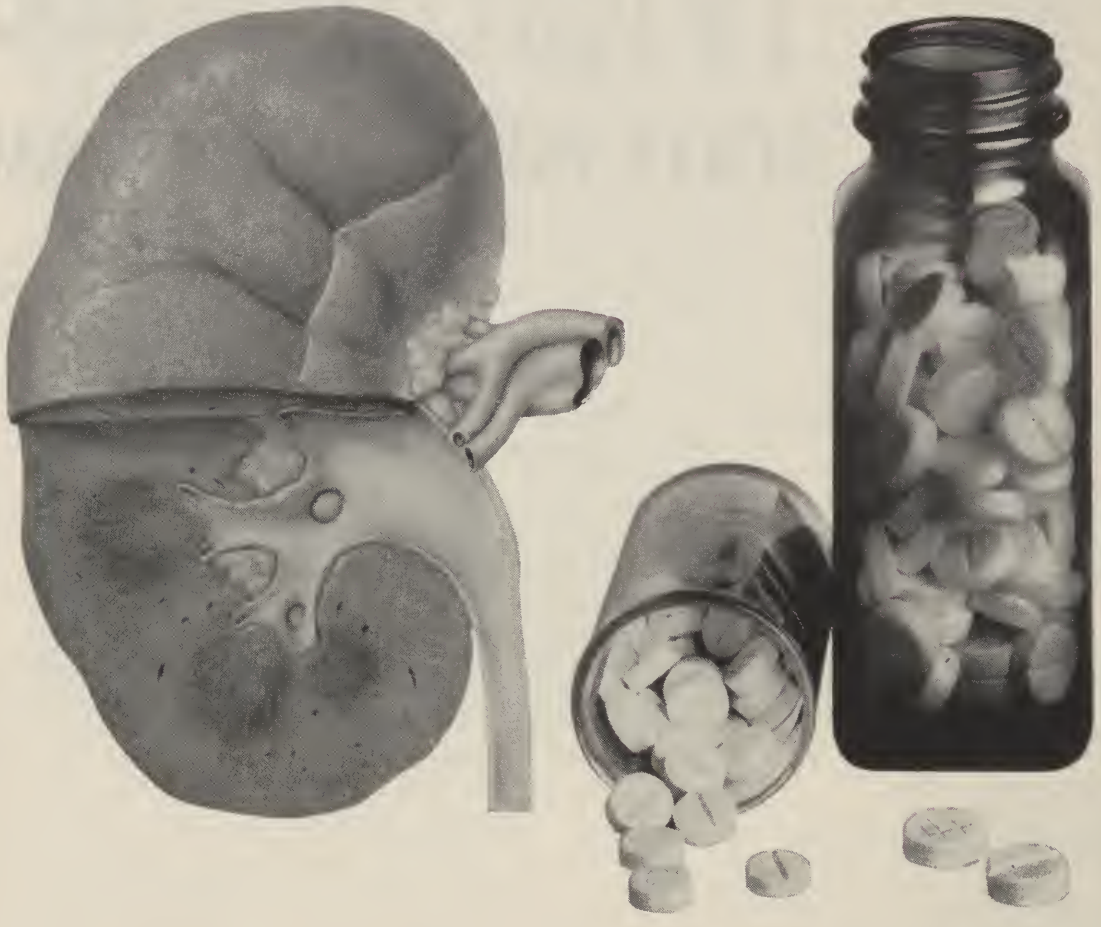
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Doctors take note...

MARK THESE IMPORTANT DATES ON YOUR CALENDAR

June 20-24—Annual convention, Americon Medicol Associotion, New York City. See JAMA May 10 for complete scientific progrom and registrotion forms.

September 10—Semionnuol meeting, Medicol ond Chirurgicol Foculty of the State of Moryland, Oceon City.

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June 7-11—State University of Iowo
"Bosic Principles in Internol Medicine."

June 9-11—New York University Medicol School
"The Hemodynomic Bosis for Auscultation."

June 14-18—University of Rochester School of Medicine
"Hemotology for Internists, in the Light of Recent Developments."

November 1-5—University of Colorodo Medicol Center
"Psychiotry for the Internist."
Inquire: Edward C. Rosenow, Jr., MD, executive director, The Americon College of Physicians, 4200 Pine St., Philodelphia, Po. 19104.

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AMERICAN CANCER SOCIETY

June 16—Drake Hotel, Philodelphia
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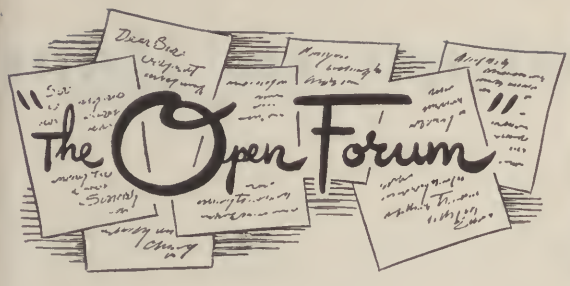
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To the Editor:

Through the kindness of Dr. Charles N. Davidson, I have been given the privilege of reading the March issue of the MARYLAND STATE MEDICAL JOURNAL, with its excellent article on "Medicine and Religion."

However, I was distressed to find that no response had come to you from the Presbyterian Church in response to your inquiry regarding "Religious Practices of the Major Faiths." May I ask to whom you addressed your inquiry? I myself was for four years Chairman of a Committee of the General Assembly of the United Presbyterian Church which prepared a report on the same subject of Christian faith and health and we offered a recommendation adopted by the General Assembly with respect to the relation of the Holy Communion or Eucharist and the sick. I am concerned that you had no answer from the Presbyterian Church and wonder if your inquiry did not fall into the wrong hands.

Paul C. Warren, ThD

(EDITOR'S NOTE: *Dr. Warren is minister of The Second Presbyterian Church, Baltimore. In reply to his letter, we asked him to prepare a brief statement, which follows.)*

The United Presbyterian Church strongly urges a close working relationship between physician and pastor in the sick room. The pastor's part is that he be the means of surrounding the patient consciously with the love of God and the resources of Christian faith. This may involve prayer through which faith is strengthened, of the laying on of hands to convey the sense of the presence of God, or, if the patient desires it and is sufficiently composed to receive it meaningfully, to administer the Holy Communion. "In terms of both Christian belief and Christian experience the Sacrament communicates the Gospel."



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A MEMORIAL LECTURE IS BEING ESTABLISHED by the Medical and Chirurgical Faculty of the State of Maryland in honor of Amos Ralph Koontz, MD, who died February 3. The lecture will be financed by contributions from his colleagues and friends.

On March 30, the state legislature passed a resolution honoring his memory.

A dynamic participator in professional, educational, political, social, educational, and military affairs, Dr. Koontz held numerous positions of leadership at the time of his death, including that of Councilor of the Medical and Chirurgical Faculty. He was also editor of *Military Medicine;* president of the Southeastern Surgical Congress, the Mid-Atlantic Chapter of the American Medical Writers' Association, and the St. George's Society of Baltimore; chairman for Maryland of the United States Committee of the World Medical Association; and councilor for Maryland of the Southeastern Surgical Congress. In all, he was active in 19 professional societies and 25 other societies and clubs.

Dr. Koontz was a surgeon of international reputation. Hernia repair was his particular interest, and he developed a number of new operative techniques. He had written and lectured extensively on this subject. He was a diplomate and one of the founders of the American Board of Surgery and was a Fellow of the American College of Surgeons.

Often disagreed with but always respected, Dr. Koontz spoke out vehemently in support of that which he believed. He was a champion of free enterprise and individual freedom and ardently opposed anything which might diminish that freedom. Through articles, editorials, and letters to the editor, he expressed his convictions forcefully and deplored those who acted without full knowledge and those who did nothing at all.

His deeds were consistent with his words, and Dr. Koontz vigorously campaigned for political candidates who would preserve constitutional freedom. In 1952 he headed the Professional Committee for Eisenhower in Maryland. More recently, he was active in the formation of the Maryland Medical Political Action Committee.

Dr. Koontz was a soldier in both World Wars. In World War I he was among the first convoy of troops that went to France. He had just completed his third year of medical school and went as a private with the Johns Hopkins Unit. Officers of the unit were teachers in the medical school, and he and his classmates completed their fourth year in France

Dr. Koontz

and were granted their medical degree in April, 1918.

In World War II, Dr. Koontz reactivated and commanded the Johns Hopkins Unit. Ultimately he was made chief surgeon for the U.S. Army Forces in the South Pacific Area. After World War II he served on the State Staff Maryland National Guard and retired in 1957 with the rank of brigadier general.

Few parts of the world were unknown to him. Dr. Koontz traveled extensively in all six continents as well as the islands of the East and West Indies and those of the Pacific. He made four complete trips around the world. He made special missions to India to perform a number of operations, and he operated in Dr. Albert Schweitzer's hospital in Africa. In 1961 he spent a month as a surgeon for MEDICO in Cambodia and Malaya.

Born in Virginia in 1890, Dr. Koontz descended from a line of distinguished ancestors. He attended the College of William and Mary, receiving a Bachelor of Arts and a Bachelor of Science degree in 1910 and a Master of Arts degree in 1911. After teaching biology at William and Mary for four years, he entered the Johns Hopkins University School of Medicine, from which he received his Doctor of Medicine degree in 1918.

Dr. Koontz was assistant professor emeritus of surgery at the Johns Hopkins University School of Medicine. He was also a staff member of the Johns Hopkins Hospital and numerous other Baltimore hospitals. He was consultant in surgery for the Surgeon General of the Army and for the Surgeon, Second Army.

He is survived by his wife, the former Besse Erving Stocking, and a son, James William Koontz, II.

Doris E. Fletcher

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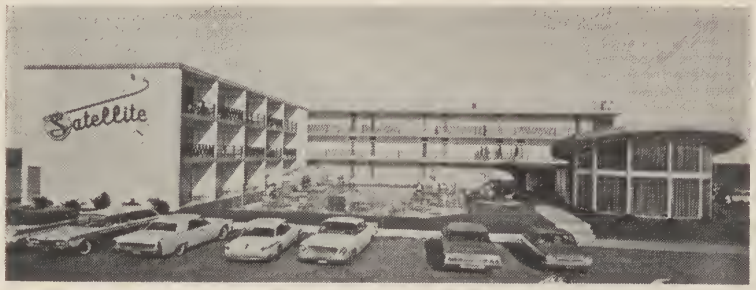
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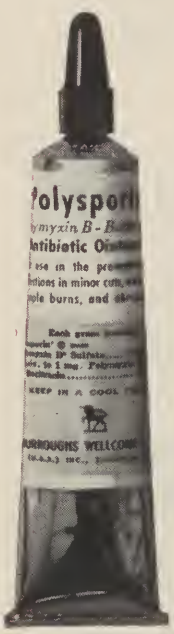
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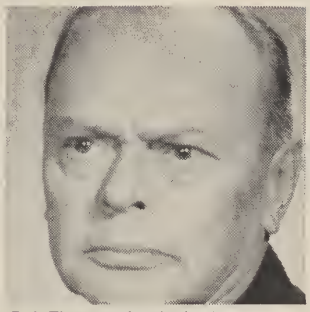
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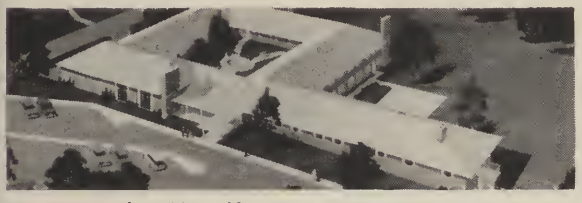
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EXECUTIVE SECRETARY'S NEWSLETTER

May, 1965

SEMIANNUAL MEETING RESOLUTIONS

Resolutions for consideration at the Semiannual meeting in Ocean City, September 10, 1965, must be in the Faculty office by

FRIDAY, JULY 16, 1965

in accordance with the Bylaws, Article X, Section 22.

PHYSICIANS' RESPONSIBILITY

Physicians are reminded that they are responsible to see that newborn infants receive a test for PKU (Guthrie) within 5 days of date of birth.

While hospitals will routinely set up procedures for such tests to be administered, physicians are reminded that tests must be done on all newborns delivered outside of hospitals. Individuals whose religion prohibits such tests are excused from the requirements of the law.

WORK PERMITS FOR MINORS

Effective June 1, 1965, work permits for minors may be issued by the Family Physician. Up until this time, work permits had to be issued by physicians designated by the Labor Department.

A change in the last session of the State Legislature removed this requirement from the law, effective June 1, 1965. The previous payment by the Labor Department of a $2.00 fee for this service remains in effect for those physicians who are so designated as qualified physicians by the Labor Department.

NEWS NOTES

Nathan Stofberg, M.D., is now associated with Drs. Herbert Copeland, Nathan Hyman and Albert Shackman in the private practice of diagnostic and therapeutic radiology.

Drs. Paul F. Guerin and Watson Kime have established an additional office for the practice of laboratory medicine at 6116 Belair Road, Baltimore, 21206.

FACULTY'S HOUSE OF DELEGATES ACTION

Actions by the Faculty's House of Delegates in meetings on Wednesday, April 21 and Friday, April 23, included the following:

1. Adopted a resolution instructing the Council to distribute a questionnaire requiring each member to return a statement in writing that he either is or is not disposing of his professional attainments or services to any hospital, corporation or lay body, by whatever name called, or however organized, under terms and conditions which permit the sale of services of that physician by such agency for a fee.

2. On recommendation of the Reference Committee, rejected the following 3 resolutions:

   1A/65 - Incorporation for Professional Persons

   2A/65 - Polling of Physicians on Social Security

   3A/65 - Return of Grant of the Tobacco Industry to the AMA

3. Rejected a resolution introduced by the Baltimore City delegates which would have made the assessment action of February 20, 1965, voluntary for all members.

ANNUAL REPORTS

Copies of the Annual Reports of Faculty Committees and Officers are available to members through the Faculty office.

WELCOME BACK

Merck, Sharp and Dohme, Inc., has returned as one of the Journal's regular advertisers following several years absence.

NEWS NOTE

Diplomate of the American Board of Psychiatry & Neurology, Eli Breger, M.D., has been certified in Child Psychiatry.

John Sargeant
Executive Secretary

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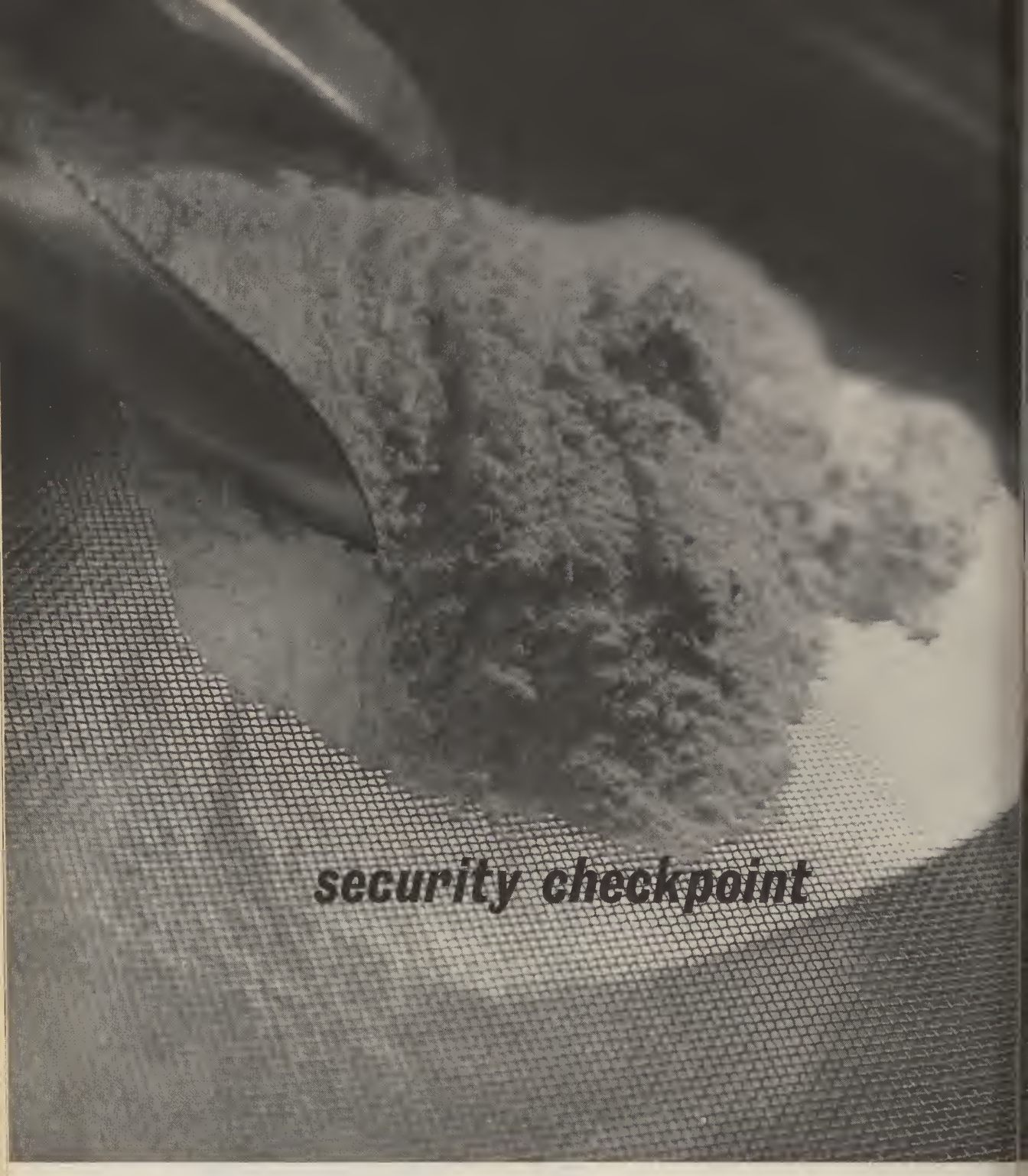
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Maryland State Medical Journal
Vol. 14, No. 5
May, 1965

Editorial

The AMA . . . .

ROBERT vL. CAMPBELL, MD
President, Medical and Chirurgical Faculty of the State of Maryland

The American Medical Association has been under fire from the leaders of government to an extent never before experienced by any private organization. This is to be expected in view of the conflict over Medicare. But we are disturbed over the widespread criticism from within our own profession. This criticism is to be welcomed if based on facts; I think, however, most of us need to be reoriented in our concept of the American Medical Association. I have been a delegate to the AMA for 10 years. I quite frankly admit that I had a chip-on-the-shoulder attitude in the beginning. If these years of experience have produced anything, it has been the recognition that the American Medical Association is a democratic organization which is representative of the opinions of the majority of members of the medical profession in the United States.

By nature, a democratic form of government lacks an expeditious quality compared with a totalitarian form of government. This would be a just criticism if there could be one man at the head of a totalitarian organization who is all-wise, never-erring, and sensitive to the wishes of the majority. Naturally, such a person does not exist. Therefore, opinion and policy must be formed through representatives, i.e., delegates. The Board of Trustees of the AMA can act only within the confines of the policies set by the House of Delegates. Often the very nature of the democratic process is reaction rather than action. Who was it said that the democratic form of government is a bad one, but all other forms of government are so much worse?

We all refer to "the AMA" as though it were an individual who could parry and thrust at will with an adversary regardless of the desires of the majority. The American Medical Association represents some 200,000 physicians. Among these are some who are critical of its views. The usual complaint of its detractors is that the association is not representative. Many believe that because of this, they should drop their membership. It would be just as logical to give up one's citizenship if the United States government passed a law



Robert vanLieu Campbell, MD, general practitioner in Hagerstown, is the 1965-66 president of the Medical and Chirurgical Faculty. He has been a Faculty delegate to the AMA for 10 years and was chairman of the Faculty's Reference Committee for several years. He has served also on the Public Relations Committee, the Corporate Practice of Medicine Committee, the Policy and Planning Committee, and the Ad Hoc Committee on Osteopathy.

Dr. Campbell was born in 1917. He graduated from the University of Maryland in 1935 and pursued his medical education at Duke University School of Medicine, graduating in 1939, then interning at Baltimore City Hospitals. He went to London in 1939 to study pediatrics as an exchange student at St. Bartholomew Hospital. In 1942 he attended the School of Tropical Medicine, Walter Reed Army Hospital.

He served in the United States Army from 1942 to 1946, whereupon he returned to Hagerstown and began general practice. Active in the Washington County Medical Society, he was its president in 1963-64. He is also a past president of the staff of Washington County Hospital.

which was not to one's liking. In any democratic organization the right to criticize is basic, but the representation must be that of the majority of its members; so it is with the AMA. Dissenters should nevertheless support the policy adopted by the majority. Instead of resigning from the society they should take a more active part in their local and state medical societies and thereby make their views known. This is the democratic process.

The present argument over Eldercare-Medicare has obscured the many other positive programs of the AMA, such as the 14 bills that the AMA supported last year; bills which, for instance, exempted non-profit blood banks from antitrust law and extended federal aid for building new hospitals; the $2.3 million spent to guarantee bank loans to medical students; the establishment of the great standards for this country's medical schools; the new Institute for Biomedical Research being built; and the fact that AMA is the new watchdog of our nursing homes and has accredited 500 of this country's 9000 such institutions.

In my opinion, unfamiliarity with the American Medical Association breeds contempt. I would ask that as many of our membership as can attend the deliberations of the AMA's House of Delegates and hearings. They will soon learn that the AMA is much like a large county medical society, that rank and file members express divergent views, but the final opinion is actually a distillate of these views after free discussion by knowledgeable physicians as yourselves. All the efforts of the organizations have not been and will not be crowned with success. This does not necessarily mean that the decisions have been wrong or that effort has not been expended. The views, by and large, are conservative because most physicians in this country seem to have a conservative approach. I make a plea, therefore, for some degree of confidence in your selected representatives and for a philosophical point of view toward this grand but often frustrating process called democracy.

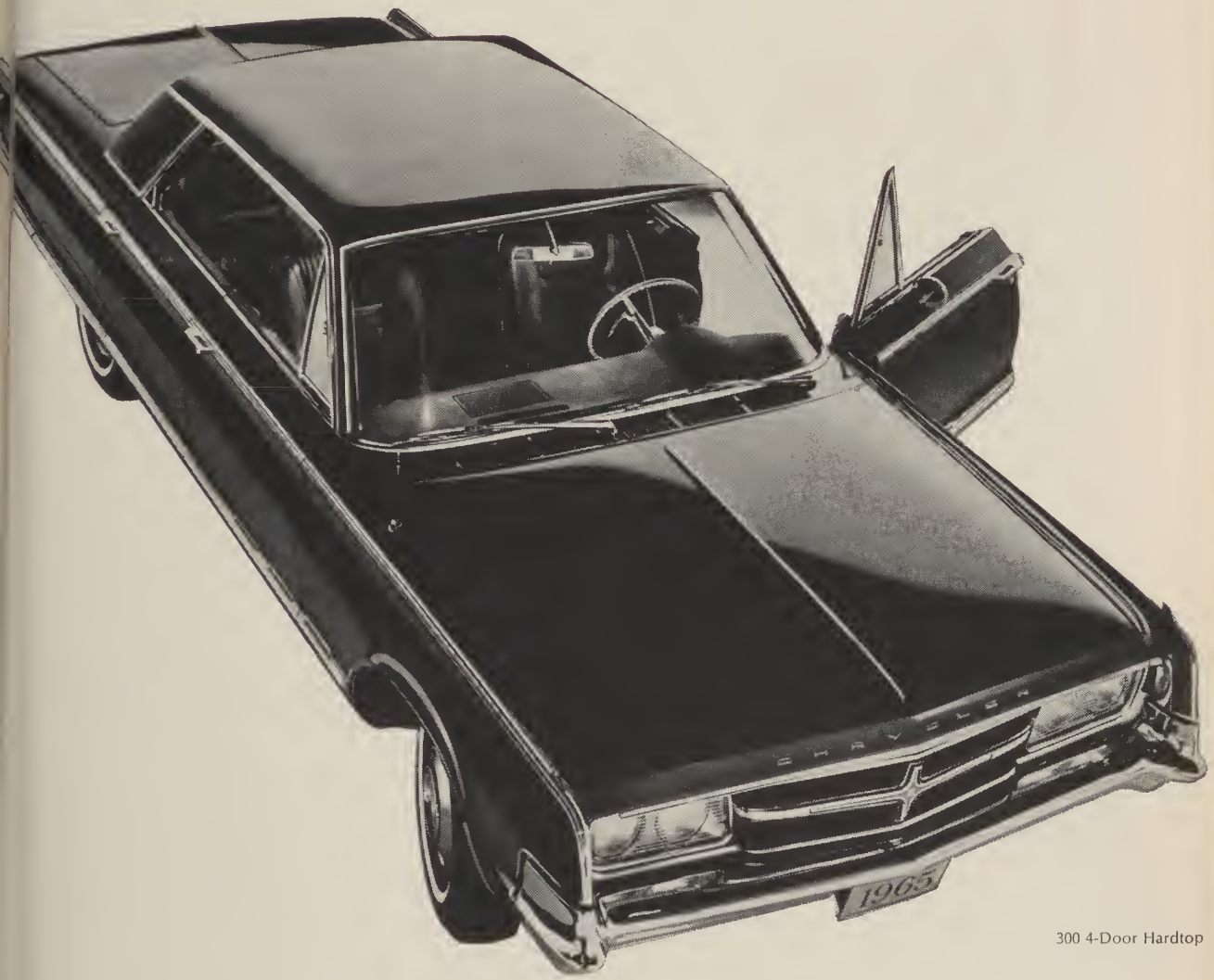
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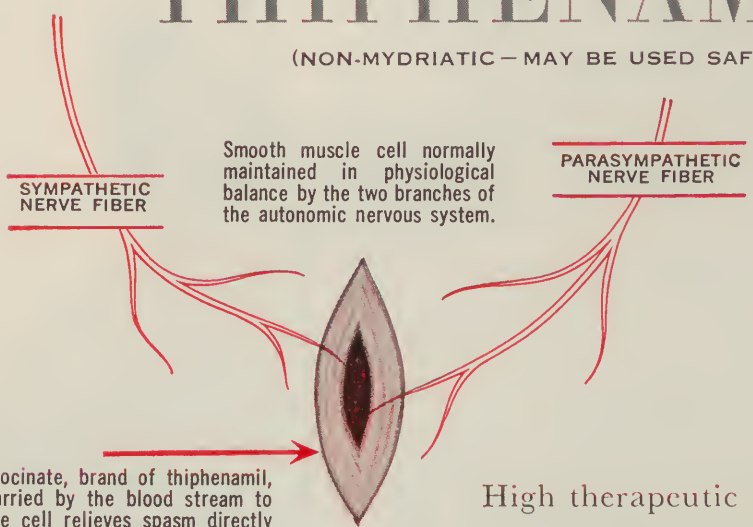
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COUNCIL, MARCH 18

1. A moment's silence was observed in memory of Amos R. Koontz, MD, deceased member of the Council.

2. Physicians defense was approved for two physicians requesting it.

3. Emeritus membership is to be recommended for Harry H. Hamilton, MD, Kent County, and William W. H. Warthen, MD, Baltimore County.

4. The dues of a Baltimore County physician were remitted because of illness.

5. The insurance commissioner has refused the request of Blue Shield to abolish hospital educational funds and payment by Blue Shield to such funds. The Mediation Committee is studying this matter and will report to the Council.

6. The Council approves in principle the testing of all newborn infants for PKU within the first five days of life.

7. A recommendation to establish a memorial lecture in memory of Amos R. Koontz, MD, was approved. Funds are to be obtained by voluntary contributions from the public and members of the profession.

8. On recommendation from the Subcommittee on Alcoholism, the Council emphatically endorsed the 1956 resolution of the AMA House of Delegates that alcoholism is a disease and is medically treatable, and acute alcoholism is a medical emergency and should therefore be treated in all general hospitals. The Subcommittee on Alcoholism is to continue its efforts to get individual hospitals to admit alcoholics.

9. The Ad Hoc Committee on Osteopathy presented its report, which was adopted with one amendment.

10. A legal opinion has been obtained to the effect that an assessment is compulsory, not voluntary; that the House of Delegates may impose an assessment in accordance with the Faculty Bylaws; and that the payment of any such assessment could be made any time up to and including the payment of 1966 dues, inasmuch as the Bylaws provide for this manner of payment. Dues for 1966 could not be accepted without payment of the assessment.

EXECUTIVE COMMITTEE, APRIL 1

1. Certain aspects of the $50 assessment of members were clarified:

A) It is an assessment and must be paid before 1966 dues can be accepted.

B) Physicians in their first or second year of practice are exempt from the assessment even though they may be paying full active dues. To be exempt, a physician should not have completed his second year of practice by February 20, 1965, the date the assessment was levied.

C) Those members who have paid this assessment without questioning their liability are to be notified that they are not liable, and they may have a refund if they wish.

D) Funds collected in this manner will come under the Treasurer, in accordance with the Bylaws. They will be kept in a separate fund and used only for the purpose designated by the House of Delegates. Investment income from the funds will accrue to the educational fund.

2. The new State Health Commissioner is to be advised that the Council would appreciate his attending any meetings at which he would like to discuss pertinent matters and that he will be invited whenever there is anything on the agenda in which he might be interested.

3. Recommendations were made for appointments to the Advisory Council on Medical Care, State Department of Health, and to the Physical Therapy Board of Examiners.

4. The Executive Committee agreed to recommend to the Council: A) Appointment of an ad hoc committee on tuberculosis to study this problem and make recommendations to the Council at the June, 1965, meeting; B) approval in principle of the formation of a Maryland Tuberculosis Commission by the Governor.

5. A member requested legal defense for an incident that occurred while he was a hospital resident and before he became a Faculty member. It was regretted that such privileges could not be given for incidents that occurred before he became a Faculty member; however, if another physician who is a member in good standing should be sued in the same case, the privileges of panel consideration can then be extended to him.

6. A donation of $50 to the National Society for Medical Research was approved, as this sum had been included in the 1965 budget.

7. No further suggestions were offered as to changes in the housekeeping revisions of the Medical Practice Act. This will be considered again when the printed copies of the proposed changes are made available.

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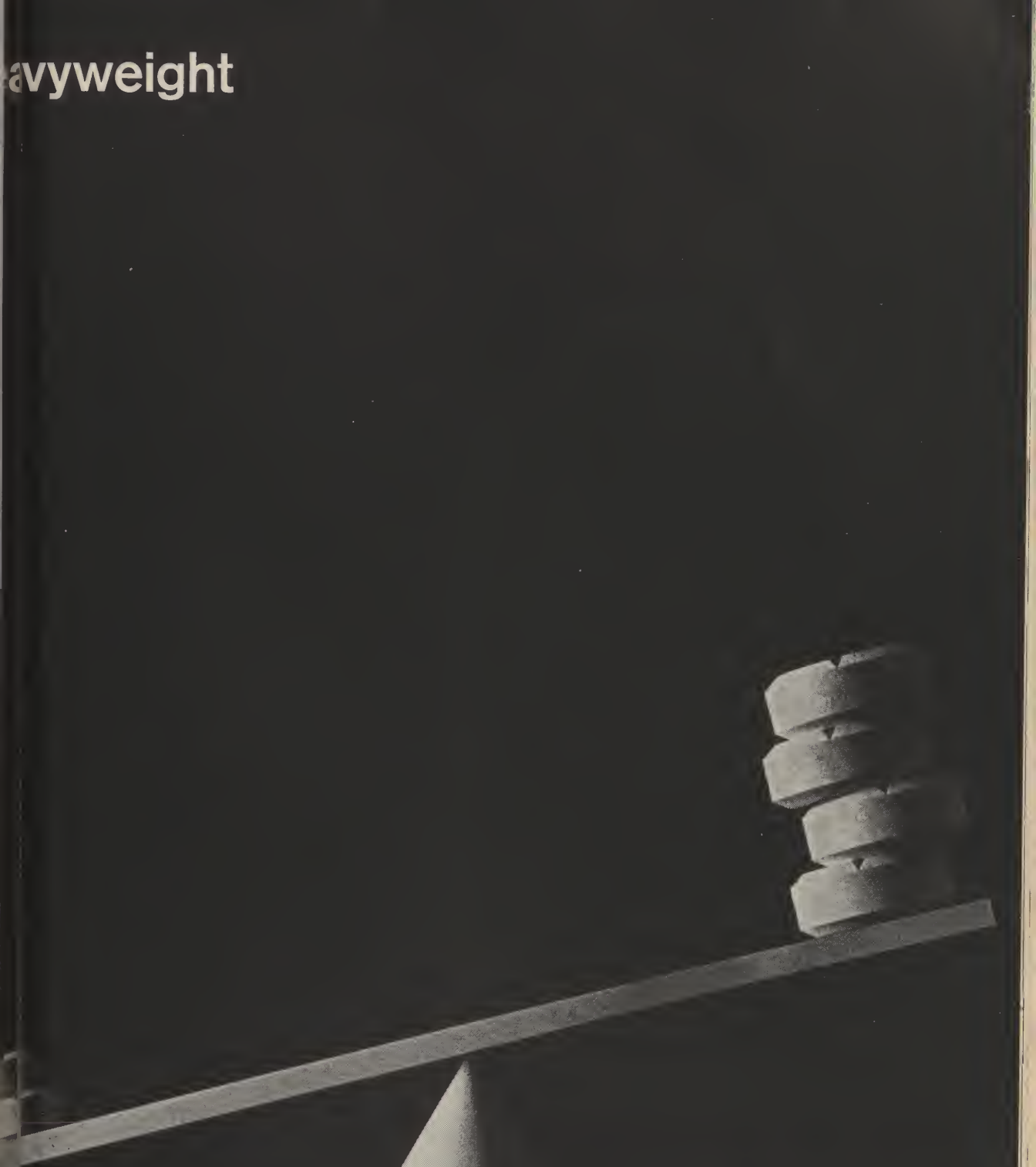
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*Swartz, C., et al.: Circulation 28:1042, 1963.

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THE IMPARTIAL MEDICAL WITNESS PROJECT

Why juries should not be abolished in favor of court-appointed medical experts in personal injury cases.

PAUL BERMAN
Member, Baltimore City Bar

IT HAS BEEN SUGGESTED that some of the antagonism between our professions can be eliminated, in cases where there is a dispute among the medical witnesses, by having courts appoint an impartial medical witness as *amicus curiae,* a court-employed expert. I am opposed to it for a number of reasons. Such a proposal is but one facet of the campaign that has been and is being waged in some quarters for the abolition of jury trials in all personal injury litigation.

Because of the enormous increase in the volume of litigation in the past decade, resulting primarily from the tremendous increase in the number of automobiles, and the consequent delay of between two to four years, in some jurisdictions in reaching cases for trial, the jury system has been assailed and its abolition advocated by a few lawyers, some judges, and a few professors of political science.

The jury system in personal injury cases is attacked chiefly on the following grounds:

1. Jury trials are too slow and cumbersome for our fast moving age.
2. Jury trials are congesting our court calendar so that justice is denied by being delayed.
3. Jury trials are too costly.
4. Personal injury cases present issues involving medical testimony which are invariably beyond the comprehension of the average juror.

The arguments for the court appointment of medical experts in personal injury cases parallel the arguments advanced for the complete abolition of jury trials, and I have found that generally both these reforms are advocated by the same people.

First, the advocates of both reforms claim that they offer a short cut in the disposition of cases, in encouraging and forcing settlements, thereby saving the time of the court and expense to the taxpayers.

Second, both reforms are rooted in a basic distrust in the competence of the jury to decide technical questions on the basis of conflicting expert testimony and in the feeling that medical science is such that if all partisan bias is eliminated in a witness, his opinion will be in accordance wth scientific TRUTH. In my opinion, the arguments advanced in support of the appointment of so-called impartial medical experts are unsound.

There is an instructive historical precedent which shows what can happen as a result of the practical conclusiveness of impartial medical testimony with the trier of fact. Dean Roscoe Pound[1] refers to the following case:

> In the English Witchcraft Trials in 1664 an experiment conducted by some skeptical persons threw doubt upon the testimony for the prosecution. Thereupon the Court called Sir Thomas Brown, a leading physician of the time, and as the report tells us, "a person of great knowledge." After hearing the evidence and seeing the children claiming to be bewitched, he gave it as his opinion that they were, and told of some recent cases in Denmark where there were the same manifestations,

Part of a talk entitled "Some Observations by a Trial Lawyer on Cooperation Between the Legal and Medical Professions," given May 23, 1963, at a joint meeting of the Bar Associations and Medical Societies of Allegany and Garrett Counties. Mr. Berman's address is being published in three parts.

and explained how the witches had operated. The Court could do no more than accept the opinion of so great an authority.

The advocates for the appointment of medical experts by the court are really striking at the essence of the jury system attempting to accomplish indirectly what they have not been able to accomplish directly, that is, the abolition of jury trials in personal injury litigation.

In practice, I have found that the jury is rarely misled by the divergence of opinions of experts selected by the parties. The jury hears the evidence, appraises the plaintiff and all the testimony, and uses common everyday sense in arriving at its conclusions and verdict; and the jury can sense dishonesty in a physician just as in any other witness.

In an adversary proceeding, such as we have in a trial by jury in this country, it is the function of the jury to decide all factual questions based on the evidence produced by the parties. The jury is particularly qualified to perform this function.

Mr. Justice Hunt, in *Sioux City and Pacific R. R. Co. v. Stout,* 84 U. S. 657 at 664 (1874), clearly pointed out the capacity of a jury to decide disputed questions of fact, and said:

> It is this class of cases and those akin to it that the law commits to the decision of a jury. Twelve men of the average of the community, comprising men of education and men of little education, men of learning and men whose learning consists only in what they have themselves seen and heard, the merchant, the mechanic, the farmer, the laborer; these sit together, consult, apply their separate experience of the affairs of life to the facts proven, and draw a unanimous conclusion. This average judgment thus given it is the great effort of the law to obtain. It is assumed that twelve men know more of the common affairs of life than does one man * * *.

And now that we have added the ladies, I have found that the quality of our juries has greatly improved.

I do not, of course, claim that our system of trial by jury is perfect. We will probably never have a perfect system for the administration of justice, either civil or criminal, because human nature is not perfect. However, after an experience of 42 years with our system of jury trials and a full consideration of the results of that system, it is my opinion that it is the best of all systems and that the constitutional provisions guaranteeing the right to a jury trial have resulted from the quiet, prolonged, and fundamental thinking of the sovereign people.

The essential flaw in the position of the proponents of the plan for impartial medical testimony is the fact that medicine is not an exact science, and medical opinions cannot be given with absolute mathematical certainty.

In the course of a symposium on "The Doctor in Court—Expert Medical Testimony"[2] conducted by the Medical and Chirurgical Faculty of Maryland, Dr. George O. Eaton, an eminent surgeon of the City of Baltimore, in discussing the viewpoint of the traumatic surgeon, said:

> Given exactly the same facts, even conscientious experts can and will disagree with regard to their significance and potentialities, so that the mere disagreement between experts does not imply dishonesty or incompetence on the part of one or both of them.

Despite the great advances that medicine has made in the past two decades, the honest differences of opinion in medical matters, particularly in the realm of traumatic medicine, are really amazing.

The Report of the Special Committee of the Association of the Bar of the City of New York on the Medical Expert Testimony Project catalogues the types of cases referred to panel physicians by the courts of New York. Without attempting to point out all of the differences of opinion that exist between various experts in the field of traumatic medicine, let us examine the various types of cases which the report states were so referred. We will first discuss postconcussion syndromes. The Report of the New York Project, page 22, states:

> As might be expected, injuries carrying few objective symptoms are prominent. About 40 per cent of all cases referred to impartial experts involve claims of postconcussion syndromes.

Two schools of thought exist concerning the "postconcussion syndrome." Drs. Strauss and Savitzky[3, 4] are of the opinion that this syndrome (which is characterized by headaches, dizziness, fatigability, emotional irritability, and vasomotor instability) is to be explained on an organic basis, even in its psychological manifestations. On the other hand, Dr. F. M. R. Walshe[5] takes the extreme opposite view, offering the opinion that all such syndromes are purely functional and should be ignored.

Undoubtedly the experts for the plaintiff who describes the symptoms of postconcussion syndrome will take the position that it is the result of trauma and is disabling, while the experts for the defendant will take the opposite view. All of them will have respectable authority to sustain their positions.

The report further states, "About 7 per cent involve claims of back injuries." Up to 1935 I don't think any of us ever heard of a ruptured intervertebral disc or a herniated nucleus pulposus. In an article entitled "The Medico-Legal Aspects of Low Back Pain" by Dr. Ben R. Wiltberger,[6] it is stated:

> During the past ten years the majority of authorities have changed their concept of low back pain and its causes and have completely eliminated such diagnosis as lumbago, sacro-iliac and lumbosacral strain. It is now the consensus of opinion among such well-known authorities as Doctors MacNab, Harris, Key, Kimberley, Caldwell, Shutkin, as well as many others, that, percentage-wise, the intervertebral disc is involved in the large majority of cases of idiopathic low back pain. These men feel that the intervertebral disc is involved in approximately seventy-five per cent of the cases of all low back pain, and they divide the pathology into degenerated lumbar discs and ruptured intervertebral discs.

It is further stated:

> The pain from an acute, ruptured, intervertebral disc is usually so severe and incapacitating that it is necessary for the patient to be completely immobile for a period of days or weeks. It is typical for this type of disc pain to be periodic, and the patient may become symptom free for days or weeks at a time only to have a recurrence of the pain at a later date. For this reason the same individual may be examined by two competent orthopedic surgeons on different dates with varying physical findings, a fact which is difficult for attorneys and jurists to understand.

Under such circumstances, how can an expert appointed by the court, who may examine a plaintiff once or even twice, make a proper diagnosis and prognosis.

In the light of what medical science has now demonstrated to be the true cause of chronic low back pain following trauma in a vast majority of the cases, what can be said of the injustices perpetrated for many, many years against those unnumbered thousands of plaintiffs whose testimony of crippling back pain was derisively characterized by defendants' counsel as merely evidence of lumbago or simple back strain or jeeringly referred to as a "railroad spine" or a "court house spine," the symptoms of which would disappear when the plaintiff walked out of the courthouse with a verdict in his pocket? Of course, defendants' counsel can excuse their part in such injustices by saying that when they asked juries to disbelieve plaintiffs, many of whom were branded as fakers and frauds, they were misled by their doctors who, in those days, had never heard of a ruptured invertebral disc. In those days, even with the ridicule with which the plaintiff in a back case was met, he did often obtain a verdict only as a result of the common sense of a jury. If the court were to have appointed an impartial medical expert whose hallowed testimony would have disavowed any cause for the plaintiff's symptoms of pain, the plaintiff would have had no chance to be compensated for even the most crippling disability resulting from his disc. His testimony as to his symptoms and disability would simply have been disbelieved and ignored as incredible when controverted by the expert's opinion that they didn't exist because he knew of no cause for their existence.

The same situation existed until about 12 years ago with regard to traumatic whiplash injuries to the cervical region, which were virtually unacknowledged by many of the best orthopedists.

The Report continues, on page 22:

> Next in volume are fracture claims, involving 29 per cent of all references.

These require interpretation of x-rays, and occasionally there are wide differences in their interpretation. Reading and interpreting x-rays is an art as well as a science, but it is not a science like mathematics, nor is it based on any formula. X-rays do not read themselves but have to be interpreted by human beings.

The opinion of the "impartial" expert on disputed medical questions can no more represent scientific truth than the opinion of an "impartial" legal expert on a close question of law will represent legal "truth." The adversary system is best suited to precisely such questions where the issue is such that there are cogent considerations and respectable authorities on each side, and experience has demonstrated that justice is best served by permitting the considerations on each side to be stated by the authorities who espouse them as cogently as possible to the trier of fact.

In a case I tried some years ago, in which one of the most capable and outstanding defense attorneys in Maryland represented the defendant, we each had an expert orthopedist examine the plaintiff, take x-rays, and testify. Both of these experts were men of the highest character and were, by reason of experience and training, considered among the best qualified orthopedists in the city of Baltimore. Neither of them could be labeled defendants' doctor or plaintiffs' doctor. They were high class men who had the respect and confidence of everyone in Baltimore who knew them.

The doctor who testified for the plaintiff stated

that his x-rays and examination revealed a compression fracture of the fourth lumbar vertebrae. The doctor who testified for the defendant was positive that the same x-rays showed no fracture.

The court did not refer the plaintiff to a so-called impartial expert. These doctors were both as impartial as any doctor whom the court could have selected. But had the court selected a doctor to examine the plaintiff, who could tell what the result would have been. It would all depend on chance, whether the single doctor selected by the court agreed with the opinion of the doctor who testified for the plaintiff or the doctor who testified for the defendant. As it was, it was left to the jury where the element of chance was averaged out among a cross section of the community to be decided as history and experience have demonstrated all facts are best decided.

The appointment of a doctor by the court, whose opinion will be accepted like the word of an oracle, will have the effect of substituting the opinion of one person based on his own investigation for the judgment of 12 persons informed by testimony of experts on both sides of the case.

The New York Report, on page 125, states:

> Where there is a wide divergence of opinion as to what injuries exist or are claimed, the testimony of the panel physician appears to be all controlling with the jury.

And on page 127, it is stated that one of the trial judges reported:

> That he could feel a different relationship between the jury and this expert (one of the panel physicians) than the one which usually prevails between a jury and a partisan expert. It was as if the jury transferred to the impartial expert some of the confidence and respect felt toward the judge.

To make controlling in fact the opinion of a doctor appointed by the court on the medical questions involved is to give it an aura of infallibility to which it is not entitled. The opinion of such expert would be controlling because, as heretofore pointed out, it is almost impossible to overcome in the minds of the jury the impression that the court-appointed doctor is a person whose opinion is infallible, and the opinion of other doctors, if it conflicts with his, is generally disregarded. I do not believe in the doctrine of infallibility when it comes to the testimony of any witness.

In September, 1951, a committee of nine judges, headed by Chief Judge Calvert Magruder of the First Circuit, was appointed by the Judicial Conference of the United States to consider whether statutory authority should be given to federal judges in civil cases, similar to that conferred by Rule 28 of the Federal Rules of Criminal Procedure.

After a two-year study, the committee reported that:

> Upon full consideration, we have concluded that it would not be desirable, and probably would be fruitless, to ask the Congress for legislation along the lines suggested.

The recommendation of the committee was approved by the Judicial Conference, September 24, 1953.

In a trial involving private parties, as distinguished from a trial in which the public has a special interest, it is no part of the court's function to gather evidence. To do so is a dangerous administrative inroad on our legal system which, I believe, will do more harm than good. When the court undertakes to select medical experts to testify in a trial, after the parties have selected their own, it has impinged upon the duties of the advocate. Such procedure will contribute materially to bring about the end of the true advocate, the trial lawyer.

And with the end of the advocate will come more and more administrative interference with the principles upon which this country was founded.

In California, there is now a move afoot, supported vigorously by the governor of that state, to take all claims for personal injuries out of the courts and submit them for decision to a commission, such as is now done in workmen's compensation cases. And unless the courts correct the present situation, this vicious type of legislation may be adopted as a cure-all. It will be a sad day for the legal profession as well as the public if this comes about.

The trial of a case by the true advocate before a court and jury, in accordance with the long established rules of production of evidence and burden of proof, is the mainstay of our freedoms and our form of government.

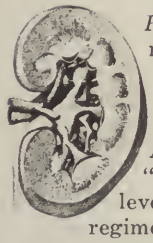
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REFERENCES

1. Pound, R: Ann Intern Med 18:449, 1943.
2. Maryland Law Rev 13:304, 1953.

(Next month: "Efforts Toward Socialized Medical Care").

One antibiotic superior to Tetracycline Chloramphenicol Streptomycin Kanamycin Polymyxin B Penicillin G against Proteus mirabilis and E. coli



Proteus mirabilis is not only the most common cause of *Proteus* infections of the urinary tract, but such infections are often resistant to other antibiotics.[1-4] According to Anderson *et al.*,[5] "When assessed in terms of serum levels attainable with usual dosage regimens, ampicillin was the most effective drug tested against *E. coli* and *P. mirabilis*." These authors found *Klebsiella-Aerobacter* and *Pseudomonas* organisms relatively insusceptible to ampicillin. With its broad-spectrum coverage of many gram-positive and gram-negative bacteria, absence of toxicity, and slow emergence of resistant strains, PENBRITIN (ampicillin) is a most beneficial and safe drug in treating urinary tract infections—*killing* the pathogens, not just suppressing them.

Dosage: Adults—500 mg. every six hours (higher doses may be required for severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Hanson, R. J., *et al.*: J. Urol. *79*:1016 (July) 1958. 2. Middletown, J. E.: Brit. M. J. *ii*:497 (Aug. 31) 1957. 3. Today's Drugs, Brit. M. J. *i*:1475 (May 26) 1962. 4. Brumfitt, W., *et al.*: Lancet *i*:130 (Jan. 20) 1962. 5. Anderson, K. N., *et al.*: J.A.M.A. *187*:87 (Feb. 22) 1964.

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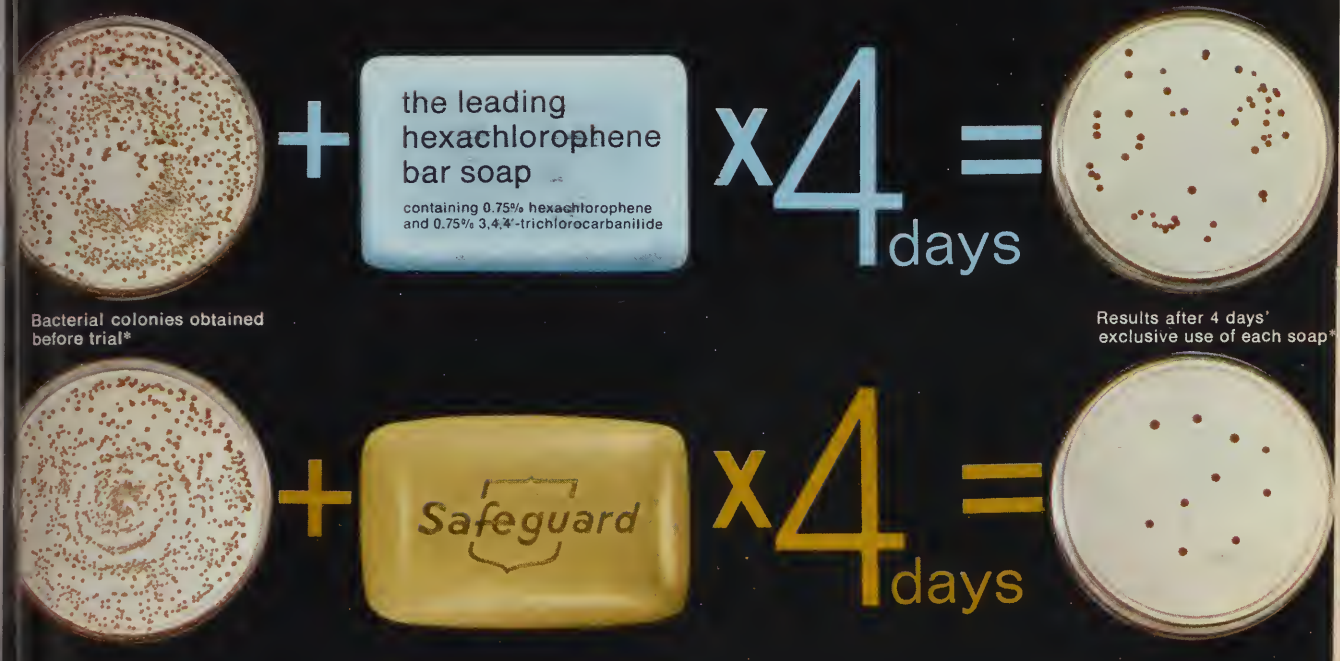
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TETRACYCLINE USED PROPHYLACTICALLY IN TRANSURETHRAL PROCEDURES

THEODORE G. OSIUS, MD
FRANK R. TAVEL, MD
and
FRANK HINMAN, JR., MD

Protection against infection from prophylactic tetracycline was evaluated by a double blind study in patients undergoing either diagnostic or operative endoscopic procedures. Results indicated no significant reduction in bacteruria, fever, chills, septicemia, or mortality by the prophylactic use of this antibiotic.

PATIENTS UNDERGOING DIAGNOSTIC and operative endoscopic procedures are frequently given prophylactic antibiotics in an effort to prevent complications from infection.[1-4] To help evaluate the usefulness of this regimen, a double blind study was performed with tetracycline and a placebo. Tetracycline was selected for study because it appeared to be the broad-spectrum antibiotic most frequently employed prophylactically in transurethral procedures.

MATERIALS AND METHODS

Two groups of patients at the San Francisco General Hospital were designated for study: a diagnostic group and an operative group. The diagnostic group consisted of 48 consecutive patients undergoing an endoscopic procedure for diagnosis. Each patient in this group was given *oral* tetracycline, 250 mg every six hours for four days, or an *oral* placebo, beginning one day before the procedure. Forty-four consecutive patients undergoing operative endoscopic procedures were given *parenteral* tetracycline, 100 mg every six hours for four days, beginning one day before the procedure, or a *parenteral* placebo for the same period of time. These formed the operative group (Table 1).

Table 1
Number of Patients Studied

Group	Administration of Tetracycline	Administration of Placebo	Total Number of Patients
Diagnostic	25	23	48
Operative	23	21	44
	48	44	92

From the Division of Urology, University of California School of Medicine, San Francisco.

Achromycin brand of tetracycline and matching placebo capsules were supplied by Lederle Laboratories, a Division of American Cyanamid Company

Table 2

Diagnostic and Operative Procedures

	Number of Patients
I. Diagnostic	
A. Cystoscopy, panendoscopy	32
B. Retrograde study	7
C. Cystoscopy, panendoscopy, urethral dilation	3
D. Cystoscopy, panendoscopy, cystogram, cystometrogram	2
E. Cystoscopy, panendoscopy, cystogram	1
F. Cystoscopy, panendoscopy, cystometrogram	1
G. Cystoscopy, panendoscopy, urethrogram, urethral dilation	1
H. Cystoscopy, panendoscopy, urethrogram, cystogram, cystometrogram	1
	48
II. Operative	
A. Transurethral resection, prostate	34
B. Transurethral resection, bladder tumor	9
C. Cystoscopy, litholapaxy	1
	44

Table 3

Diagnoses of Patients Studied

	Diagnostic Group	Operative Group
A. Benign prostatic hypertrophy	28	28
B. Carcinoma, prostate	6	6
C. Carcinoma, bladder	0	5
D. Hematuria, cause unknown	5	0
E. Hypertension	4	0
F. Urethral stricture	3	0
G. Radiation cystitis	1	1
H. Chronic cystitis	1	2
I. Tuberculosis, bladder	0	1
J. Bladder calculus	0	1
	48	44

The placebo and tetracycline capsules appeared to be identical and were kept in bottles numbered by code. Similarly, the parenteral tetracycline and placebo were alike and were in identical bottles. Neither patient nor physician knew the contents of the bottles. The dosage and duration of administration of tetracycline were selected from the recommendations of the drug manufacturer as the standard therapeutic dose for bacteremia, acute and chronic pyelonephritis, and urogenital tract infections. No patient received any other antibiotic during the study.

The diagnostic group consisted of six women and 42 men, with an average age of 69. The operative group included four women and 40 men, who had an average age of 73 years.

Forty-one lower tract and seven upper tract studies were performed in the diagnostic group. The procedures in the operative group included 34 transurethral resections of the prostate, nine transurethral resections of the bladder, and one cystolitholapaxy (Table 2).

The diagnostic endoscopic procedures took from 15 to 90 minutes and averaged 34 minutes in length. The duration of the operative procedures ranged from 30 to 120 minutes and averaged 63 minutes.

The diagnoses in both groups are presented in Table 3. In both groups, patients were included regardless of the presence or absence of urinary infection. Most patients had normal renal function.

The highest oral temperature on each of the four days was noted for the study. Patients were carefully questioned about chills. Urinalysis with methylene blue stain for bacteria was obtained before each procedure before antibiotic therapy. Urine culture and sensitivity studies by the disc method were made preoperatively, just before starting the antibiotic or placebo regimens, and again on the third postoperative day. Chills or a temperature of 101 F or higher were indications for obtaining a blood culture.

Renal function was measured by preoperative intravenous phenolsulfonphthalein (PSP) tests and serum creatinine determinations. Any side effects of the drug or placebo were noted.

RESULTS

Fever.—Temperatures above 101 F after surgery were considered abnormal. Four patients receiving tetracycline and three receiving placebo in the diagnostic group had abnormal temperature elevations. In the operative group, seven patients receiving tetracycline and 10 receiving placebo had abnormal elevations (Table 4).

Chills.—Shaking chills were thought to be present in seven patients after the diagnostic procedures; of these, four patients received tetracycline and three received the placebo. Of the nine patients who had chills after the operative procedures, four received tetracycline and five received placebos (Table 4).

Urinary tract infection.—Infected urine was present postoperatively in 37 of the 48 patients

Table 4

Results in 92 Patients Undergoing Diagnostic and Operative Endoscopic Procedures

Result	Group	No. given tetracycline	No. given placebo	Total no.
A. Temperature 101 F	Diagnostic	4	3	7
	Operative	7	10	17
B. Chills	Diagnostic	4	3	7
	Operative	4	5	9
C. Postoperative urinary infection (over 10,000 colonies/cc)	Diagnostic	19	18	37
	Operative	23	20	43
D... Positive blood cultures (of total drawn)	Diagnostic	1 of 3	0 of 2	1
	Operative	3 of 6	3 of 6	6
E. Deaths from septicemia	Diagnostic	0	0	0
	Operative	1	1	2
Total patients		48		

(77%) in the diagnostic group as evidenced by the culture of 10,000 or more colonies per ml as well as by the identification of bacteria on smears stained with methylene blue (Table 4). Preoperatively, 18 of the 48 patients (37%) had had uninfected urine; postoperatively 11 patients (24%) had uninfected urine (Table 5), and of these, the urine remained uninfected in nine. Of those patients with preoperative infection, two had a significant reduction in bacteruria postoperatively after their course of tetracycline, while the rest remained grossly infected. Preoperatively, one of these two patients had more than 100,000 colonies per ml of *Ecoli* sensitive to tetracycline; postoperatively and post-therapeutically he had 20,000 colonies of *Staphylococcus aureus* coagulase negative. The other patient also had a preoperative growth greater than 100,000 colonies per ml of *Escherichia coli* (sensitivities were not done) and postoperatively had no growth. Preoperatively, the urine of two patients contained organisms sensitive to tetracycline. Nine of the cultures contained the same organism, preoperatively and postoperatively; the rest contained another organism or became mixed cultures. The predominant organism found was *Aerobacter aerogenes* (Table 6).

In the operative group, there were 43 instances (98%) of postoperative infection of the urinary tract among the 44 patients (Table 4). Only one patient remained uninfected. This patient did not receive tetracycline. One patient had a reduction in infection and only his organism (*A aerogenes*) showed a sensitivity to tetracycline. The urine of 12 patients showed the same culture characteristics and growth before and after operation. The remainder showed new or mixed

Table 5

Comparison of Preoperative and Postoperative Urine Cultures

	Tetracycline	Placebo
1. Preoperative negative urine culture with postoperative negative urine culture		
Diagnostic group	5	4
Operative group	0	1
2. Preoperative negative urine culture with postoperative positive urine culture		
Diagnostic group	4	5
Operative group	4	4
3. Preoperative positive urine culture with postoperative negative urine culture		
Diagnostic group	1	1
Operative group	1	0
4. Preoperative positive urine culture with postoperative positive urine culture		
Diagnostic group	15	13
Operative group	18	16

Positive urine culture: 10,000 col/ml

Table 6

Predominant Urinary Tract Organisms

	Diagnostic Group	Operative Group
Aerobacter aerogenes	20	17
Escherichia coli	3	7
Proteus mirabilus	6	5
Proteus vulgaris	1	0
Proteus rettgeri	0	1
Pseudomonas	2	3
Staphylococcus aureus	4	1
Alpha-hemolytic streptococcus faecalis	1	5
Paracolon bacillus	0	3
Bacillus anitratum	0	1

cultures. Here, as in the diagnostic group, the predominant organism was *A aerogenes* (Table 6). A comparison of preoperative and postoperative urinary cultures is presented in Table 5.

Blood cultures.—Of five blood cultures made in the diagnostic group, one was positive and grew *Staphylococcus aureus,* the same organism that had been cultured from the urine. The patient was receiving tetracycline. In the operative group, of the 12 cultures made, six were positive and were equally distributed between patients receiving tetracycline and the patients receiving placebo (Table 4). Two of the patients given tetracycline had *Staphylococcus aureus* in their blood, and the third had *A aerogenes.* Of the patients given a placebo, blood culture from one had a growth of *Staphylococcus aureus* and cultures from the remaining two had *A aerogenes.*

Deaths from septicemia.—Two patients died of septicemia in the operative group: one from *Staphylococcus aureus* and one from *A aerogenes* infection. Each had the corresponding organism in his urine. The patient with infection from *A aerogenes* was not receiving tetracycline; the patient with staphylococcal septicemia was receiving it (Table 4).

Side effects from medication.—No side effects attributable to tetracycline or to the placebo were encountered in either group.

Approximately two thirds of the patients in both the diagnostic and operative groups were being maintained on indwelling urethral catheter drainage or had had other recent urethral instrumentation. They were nearly equally divided between those taking tetracycline and those taking the placebo. No correlation was seen between complications from infection and prior instrumentation or indwelling catheter.

Other complications from transurethral procedures with associated infected urine, such as funiculitis, pyelonephritis, prostatitis, epididymitis, thrombophlebitis, or periurethritis, were not included as a measurement of effectiveness of prophylactic tetracycline because their occurrence in this study was too infrequent to be of statistical significance.

DISCUSSION

The patients studied are from a county hospital population and are more susceptible to surgical complications and infection than patients from a general hospital because they are older and their urinary tract problems are frequently more advanced. They are in the hospital for a longer period of time and have a greater chance of acquiring a "hospital organism." It is precisely these elderly patients, more likely to have urinary infections and more likely to be poor surgical risks, who might best benefit from the use of a prophylactic antibiotic. The preponderance of *A aerogenes* rather than *E coli* as the predominant organism in the urinary tract suggests that many of the patients had acquired an organism resident in the hospital.

This finding is similar to that in the study of bacteremia following prostatectomy by Steyne and Logie[5] where *B proteus* was the predominant urinary tract organism, occurring three times more often than all other organisms. Most of their patients had been catheterized before operation. They concluded that catheterization was a potentially lethal procedure. In our study, the presence of urinary infection was associated with complications from infection, but the complications were not necessarily associated with prior instrumentation or catheterization per se.

These hospital organisms are more likely to cause pyrexia[2] and to be resistant to tetracycline than more common urinary flora. Only two of the routine cultures from 92 patients (both groups) showed organisms sensitive to tetracycline; both grew *E coli.* One culture of *A aerogenes* showed initial resistance and subsequent sensitivity to tetracycline, but the urine did not clear totally of bacteria. Martin et al[6] found only two of 15 patients with *A aerogenes* bacteremia whose blood culture sensitivities showed the organism resistant to tetracycline. Only three patients in both groups had any significant decrease in bacterial growth in the urinary tract. Two of these subsequently had low counts of *Staphylococcus aureus.* Less than one fourth of the preoperative urine cultures had the same postoperative growth characteristics. Either a new organism was added to form a mixed culture or an entirely different organism was grown. Organisms persisted or new growth occurred in the presence of tetracycline.

The incidence of bacteremia in endoscopic procedures was studied elsewhere and was found to be significant in the presence of urinary tract

infection.[6, 7] Nearly half of the 17 blood cultures drawn in our study showed bacterial growth regardless of the administration of tetracycline or placebo. Seven of the 16 who had chills had a positive blood culture. All of the patients who experienced chills had subsequent temperature of 101 F or higher plus an accompanying urinary tract infection. The manifestations of septicemia, elevated temperature, chills, positive blood culture, and death occurred with a nearly equal incidence among the patients receiving tetracycline or receiving the placebo. This is similar to the study of chloramphenicol by Appleton and Waisbren.[8]

The low incidence of undesirable effects from infection during endoscopic procedures in our study does not lend itself to statistical analysis, but the nearly equal distribution of these effects between patients receiving tetracycline and those receiving a placebo suggests that prophylactic tetracycline was not beneficial.

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(Dr. Osius)

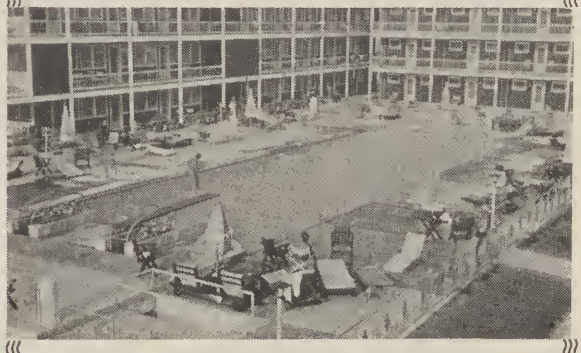
GENERIC AND TRADE NAMES OF DRUGS

Tetracycline—*Achromycin, Panmycin, Polycycline, Tetracyn*

REFERENCES

1. Creevy, C. D. and Feeney, M. J.: Routine use of antibiotics in transurethral prostatic resection: a clinical investigation. *J Urol* 71:615-623, 1954.
2. Milberg, M. B. and Hermann, H. B.: Pyrexia following cystoscopy. *J Urol* 86:823-828, 1961.
3. Prince, C. L.: The prevention of urinary tract infection following transurethral prostatic resection by combined use of sulfadiazine and penicillin. *J Urol* 56:121-123, 1946.
4. Strom, G. W. and Thompson, G. J.: The effect of sulfathiazole on febrile reactions following transurethral prostatic resections. *Proc Staff Meet Mayo Clin* 17:248-250, 1942.
5. Steyn, J. H. and Logie, N. J.: Bacteraemia following prostatectomy. *Brit J Urol* 34:459-462, 1962.
6. Martin, W. J., Spittel, J. A., Jr., Nichols, D. R. and Geraci, J. E.: Bacteraemia caused by Aerobacter aerogenes: Review of 20 cases. *Proc Staff Meet Mayo Clin* 29:541-545, 1954.
7. Barrington, F. J. F. and Wright, H. D.: Bacteriaemia following operations on the urethra. *J Path Bact* 33:871-888, 1930.
8. Appleton, D. M., Waisbren, B. A.: The prophylactic use of chloramphenicol in transurethral resections of the prostate gland. *J. Urol* 75:304-313, 1956.

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ANNE ARUNDEL COUNTY

The Anne Arundel County Medical Society met on March 17 at the Anchor Bay Restaurant, Glen Burnie. Approximately 30 members were present. After a social hour and dinner, **Marie Ryan, MD,** director of pediatric allergy, Johns Hopkins University, spoke on "Concepts and Problems in Allergy." She outlined a proposed study for children with atopic dermatitis.

President Samuel Borssuck, MD, presided over the business meeting. The payment to physicians for medical care patients was discussed. Further discussion of this matter will take place at the Board of Directors meeting. The society decided that the publication of an emergency call roster in the local paper was a public service and, therefore, endorsed its publication.

The annual dance will be held on June 5.

Dr. Borssuck announced appointments to the Nominating Committee.

A resolution was passed commending **James Hudson, MD,** and **William Thomas, MD,** for serving abroad with project HOPE, and **Drs. Aris** and **Faye Allen** for outstanding contributions in providing local service.

Sherman S. Robinson, MD

BALTIMORE COUNTY

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County, he attended public schools there. In 1896 he came to Baltimore and worked in the office of the Northern Central Railroad, saving his money for a medical education. During this time and through college he lived with his uncle and aunt, Dr. and Mrs. Horace Cowan. In 1901 he entered Baltimore Medical College, graduated in 1905, and interned at Franklin Square Hospital. Doctor Hammett then took a special course in obstetrics under Dr. George B. Scholl at the Johns Hopkins Medical School.

In 1908 Dr. Hammett came to the Long Green Valley of Baltimore County and started the private practice of medicine. In 1928 he took a summer course in general medicine at the University of Maryland. In 1932 he was appointed health officer for the Eleventh District of Baltimore County by the Board of County Commissioners and served until this office was discontinued, nearly 20 years. Dr. Hammett was elected president of the Baltimore County Medical Association in 1933. In 1948 he served on the Legislative Committee of the Medical and Chirurgical Faculty of the State of Maryland.

During World War II, Dr. Hammett worked in the administration of the Selective Service System for four years, an uncompensated patriotic service rendered his country. In 1958 he was made an emeritus member of the Baltimore County Medical Association. In 1963, the Rotary Club of Kingsville elected him Citizen of the Year, in recognition of his devoted and unselfish service to the community. He also was made an honorary member of the Rotary Club.

Starting practice in the horse and buggy days, Dr. Hammett used horseback with saddlebags through snowdrifts and to isolated homes to tend the sick. After the coming of the Model T Ford, transportation was faster, but many times he walked a quarter of a mile through the snow and mud carrying a 25-pound bag of medicines and necessary supplies. He delivered many hundreds of babies, many times receiving little or no compensation. He is proud that he never had a maternal death while practicing obstetrics, even though oil lamps and teakettles of hot water were the standard preparation for the blessed event.

Dr. Hammett's wife, the former Mary Bennett,



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is active in the Woman's Auxiliary, having served as president of the Baltimore County and Medical and Chirurgical Faculty Auxiliaries.

The Hammetts have one son, Major Walter Howard Hammett, USA, retired, and one grandson, a student at Southern Illinois University.

Dr. Hammett is a member of the Baltimore County Medical Association, the Medical and Chirurgical Faculty of the State of Maryland, the American Medical Association and the 50-Year Club, and a member of the Episcopal Church.

* * * *

The regular meeting of the Baltimore County Medical Association was held at the Rosewood State Hospital on March 17. After a delicious luncheon, the meeting was called to order by the president, **John Snyder, MD.** Dr. Snyder stated he had received a letter from one of our members complaining that our business meetings are too long and that the meetings end too late. This will be rectified, according to our president.

Donald Roop, MD, chairman of the Board of Governors, gave a report of that group. On proper action, the Board approved **Dr. William Warthen's** request to be made an emeritus member, and the dues of **Mary Cushing, MD,** were waived for 1965 because of illness. A report was given on a letter which has been received concerning physicians' having offices in RG areas (group houses). There has been much disapproval of physicians' practicing in residential areas because of inadequate parking. A committee consisting of **Mr. William Wells,** attorney to the Society, **Charles Williams, MD,** and **Gordon Grau, MD,** was appointed to study the matter and make recommendations to the zoning board. The Board approved a motion that for every member who pays $25 to the state society toward the special assessment of $50, the Baltimore County Medical Association will pay $25.

Barbara Hudson, MD, made a brief report on the LaLeche League. This organization encourages mothers to breast feed their infants. Anyone wanting more information concerning the LaLeche League may call 484-1553.

J. Morris Reese, MD, has been nominated president-elect of the Medical and Chirurgical Faculty.



John Snyder, MD, president of the Baltimore County Medical Association.

DOCTOR'S DAY CELEBRATION IN BALTIMORE COUNTY



Left to right: Mrs. John Snyder, Congressman Clarence Long, Mrs. Long.

William McLean, MD, associate professor of pediatric neurology at the Johns Hopkins Medical School, gave an address entitled "Patients with Abnormal Chromosomes in Mental Institutions." At the conclusion of the talk, **Dr. Krieg** introduced **Glyne Williams, MD,** the new superintendent of Rosewood Hospital, and thanked him and his staff for the invitation to hold our meeting at the hospital.

* * * * *

A record-breaking social hour sponsored by the Woman's Auxiliary ushered in the annual celebration of Doctor's Day at the Tail of the Fox on March 14. After a delicious dinner, **John Snyder, MD,** president of the Baltimore County Medical Association, introduced the following distinguished guests from Med-Chi: **Robert Campbell, MD,** president-elect; **William Pillsbury, MD,** secretary; **J. Morris Reese, MD,** first vice president; **M. McKendree Boyer, MD,** immediate past president; and **John Sargeant,** executive secretary. **Richard Potter, MD,** deputy state and county health officer, and Congressman **Clarence Long** were also among the distinguished guests.

Birthdays were celebrated by **Louis Dalmau, MD,** and **Elliott Flick, MD.** A smooth orchestra provided music for dancing until midnight.

Charles H. Williams, MD

WICOMICO COUNTY

"Day With Doctors Workshop," an annual medical recruitment program co-sponsored by the Wicomico County Medical Society and the Heart Association of the Lower Eastern Shore, was held at the Wicomico Senior High School in Salisbury on March 5 and 6.

"Neurosurgery Through the Ages" was the topic of the keynote speaker, **John D. Sharrett, MD,** instructor in neurological surgery at the University of Maryland School of Medicine.

Members of the Wicomico County Medical Society met with small groups of students from a three-county area of the Eastern Shore on Saturday for specialty discussions. Participating in this part of the program were

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Also on the program were a film, "The Making of a Doctor," and a tour of the Peninsula General Hospital.

Earl M. Beardsley, MD, and Andrew C. Mitchell, MD, presidents of the Heart Association and Wicomico County Medical Society, were guests at the dinner on Friday evening. Representing the medical society on the planning committee for the workshop was Gladys Allen, MD.

* * * * *

A cardiac nursing seminar was presented on Friday afternoon from March 19 through April 23 by the Heart Association of the Lower Eastern Shore, the Nurses Alumni of the Peninsula General Hospital, and District No 4 of the Maryland Nurses Association.

Joseph C. Fitzgerald, MD, Earl M. Beardsley, MD, John T. Bulkeley, Jr., MD, and Andrew C. Mitchell, MD, members of the Wicomico County Medical Society, were on the Nursing Committee planning the seminar. Appearing on programs were Dr. Mitchell and Dr. Bulkeley.

The programs were held in the auditorium of the Peninsula General Hospital School of Nursing.

* * * * *

The second annual Emergency Medical Training Program was presented on March 12 and 13 by the Wicomico County Medical Society, Inc., William P. Sadler, MD, and Paul V. Slater, MD, co-chairmen.

More than 100 registrants for the program represented police and fire departments, rescue squads, ambulance drivers, and industrial personnel from most counties of the lower Eastern Shore.

A welcome was extended by Henry A. Briele, MD, chief of surgery at the Peninsula General Hospital, and by Andrew C. Mitchell, MD, president of the Wicomico County Medical Society. Others appearing on the program included Joseph C. Fitzgerald, MD, Harold N. Eccleston, MD, Marcus D. Stephanides, MD, James L. Erwin, MD, John T. Bulkeley, MD, and the co-chairmen for the program.

The program was presented in the auditorium of the new School of Nursing building of the Peninsula General Hospital in Salisbury.

* * * * *

Members of the Wicomico County Medical Society, Inc., were honored by their wives on Doctor's Day, March 30, when the Woman's Auxiliary placed a large bouquet of carnations in the lobby of the Peninsula General Hospital with a sign proclaiming the occasion.

As a gesture of appreciation to the physicians on its medical staff, the hospital administration made arrangements for carnation boutonnieres to be pinned on each physician as he visited the hospital that day. A letter was given to each patient in the hospital, explaining the significance of the day and the flower.

A Doctor's Day dance was held by the Woman's Auxiliary on April 2 in the ballroom of the Wicomico Hotel, Salisbury, at which time recognition was given Seth H. Hurdle, MD, the society's nominee for the annual Community Service Award, and Robert T. Adkins, Md, immediate past president of the society.

Mrs. Kit Hargreaves

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REFERRAL FOR RADIOTHERAPY.

A Radiotherapist's Viewpoint

STEWART LOTT, MD

Associate Professor of Radiology
The Johns Hopkins Medical School

More than 60 years ago, ionizing radiation was first applied to the treatment of human cancer.[1] As with many other great discoveries, the initial observations on the biological effect of this new agent were accidental rather than planned. Originally its application to cancer treatment was almost completely empirical.

Despite many early difficulties, which were the inevitable result of the rapid and indiscriminate application of this dramatic new agent to the treatment of a lethal disease, the real palliative and curative benefits of radiation therapy were increasingly evident to both patients and practitioners. While surgery is still the curative mainstay in cancer management and chemotherapy is an increasingly useful palliative and growth restraining agent, the continued importance of radiotherapy is attested to by the fact that it is used in 75% of cancer patients at some time during the course of their illness.[3]

RADIOTHERAPY AND ONCOLOGY

The practice of radiotherapy is far removed from the technical specialty which many practitioners and surgeons believe it to be. The radiotherapist must be a cancer clinician and biologist rather than a technologist. In order to properly assess the value of radiotherapy in any given clinical situation, the radiotherapist must have not only a broad knowledge of the natural history and pathology of cancer but also a good working knowledge of what may be offered by other forms of management as well as his own. A radiotherapist is an oncologist who has a special knowledge of a particular method of treatment, namely radiotherapy.

From the Division of Radiotherapy, The Johns Hopkins Medical School and Hospital.

REFERRAL FOR CONSULTATION

Referral of a patient to a radiotherapist is referral of a patient by one physician to another for consultation and perhaps for treatment if it is indicated and the recommendation accepted.

Realizing the complexity of modern cancer management, the radiotherapist often will wish to see the patient in consultation with other specialists, depending upon the site of the disease, in order to make a balanced judgment as to the most promising approach to the management of any given problem.

Before commencing treatment, agreement between all parties on the total management policy to be followed is in the best interest of the patient. Long term and careful follow-up observation by both the therapist and the family physician is mandatory for good current treatment practice and improvement in treatment methods.

CURE OR PALLIATION

The basic aim of modern radiotherapy is the cure of cancer. As a result of experience and better radiotherapy techniques, the cure rates for equivalent stages of disease in sites such as the cervix have shown significant improvement in successive five year periods.[2] Cure by either radiation or surgery is limited by the biology and the extent of the lesion. Accessible lesions of skin or head and neck are often curable, while relatively few of the more deeply seated lesions, such as in the bronchus and the esophagus, are amenable to curative treatment.

The price of attempted cure by radiotherapy is a certain amount of morbidity and occasionally even death. The decision to attempt curative dosage must therefore be carefully weighed and discussed with the patient and the referring physician.

While we would all like to think of every cancer as potentially curable, only the inexperienced physician will fail to recognize the point of diminishing returns, beyond which attempted curative treatment is seldom, if ever, justified. In the face of advanced disease, attempts to cure may produce unwarranted morbidity, and palliative treatment or perhaps no treatment should be the decision of choice.

GOAL OF PALLIATION

Palliation is defined as "alleviation without cure." Having determined the point at which cure is no longer possible, the first duty of the therapist is to relieve symptoms and, where possible, to restrain growth and prolong useful life. He is clearly not entitled to create symptoms as a result of treatment, where none existed before.

Any offer to treat must be predicated upon a reasonable chance of positive gain. To treat because there seems nothing else to do may do both the patient and the treatment an injustice.

When palliation is the goal, total treatment times of short duration are generally desirable. Treatment may be given daily or perhaps two or three times a week, delivering as few treatments as may be consistent with reasonably prolonged symptom relief. Allowing the patient to be ambulatory and in his normal environment during the period of treatment or as soon thereafter as possible is a desirable goal. I would summarize the aim of palliative treatment as being the minimum compatible with symptom relief and restoration of function.

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of palliation achieved by radiotherapy for lesions such as mediastinal metastases with obstruction, lymph node masses, metastatic bone pain, and areas of ulceration is often satisfying and prolonged. This has been particularly true since the replacement of conventional deep x-ray therapy by supervoltage radiation in regular clinical practice. Despite significant advances in chemotherapy, radiation therapy is still the best palliative agent available in most circumstances and particularly for solid epithelial tumors. The restoration of hope and return to useful existence through palliative treatment in patients with advanced malignant disease is one of the most rewarding experiences in clinical cancer practice. This also makes the decision not to treat a difficult one to defend, even when in the best judgment of the therapist treatment may not be indicated. Close cooperation and discussion of all aspects of each problem with the referring physician is the only satisfactory solution.

RADIOTHERAPY OR PSYCHOTHERAPY

Too often a patient is told that he is being sent to a radiotherapist "for treatment" before any discussion of the problem has taken place with the therapist. If the radiotherapist does not agree that therapy is indicated, he is placed in a difficult position. If he tells the patient that in his judgment treatment is not indicated, the referring doctor is made to look incompetent. If, on the other hand, he treats the patient against his better judgment, he is compromising his principles and doing the patient and his treatment a disservice. The problem would never arise if patients were clearly referred for consultation rather than for treatment.

Patients will occasionally be referred for radiotherapy because there seems to be nothing else to do for them and because the referring doctor believes that it will at least be good psychotherapy. Radiotherapy is not the best psychotherapy for either doctor or patient. If radiotherapy is indicated, it should of course be used; if psychotherapy is required, there are better methods than ionizing radiation.

SHOULD THE PATIENT BE TOLD HE HAS CANCER?

While I do not agree with those who would bluntly and immediately inform patients that they have cancer, I do believe that in all but the most exceptional circumstances it is the physician's duty to discuss with the patient in detail the nature of the problem and how he proposes to deal with it. I believe also that the patient has a right to know the diagnosis if he wishes. In my experience, calm discussion of the whole problem with the patient pays untold dividends in securing his cooperation and promoting trust between doctor and patient. If radiotherapy is to be given, the patient must be told why he is being so treated. It is much better if the explanation is given by the referring doctor than by the radiotherapist.

In summary, referral for radiotherapy means, first of all, referral for radiotherapeutic opinion and then perhaps for treatment. The best interest of the patient will be served if the radiotherapist works closely with his colleagues in medicine and surgery both in consultation and in treatment. Radiotherapy remains a real source of palliation and limited cure for the cancer patient.

REFERENCES

1. Finzi, N. S.: The Early Days of Radiology, *Clin Radiol* 12:143, 1961.
2. Green, L. S., and Muirhead, W.: Improvement in The Results of Treatment of Carcinoma of The Cervix, *J Canad Asso Radiol* 14:191, 1963.
3. Paterson, R.: Radiological Achievement 1937-1960, *Amer J. Roentgenol* 96:521, 1961.

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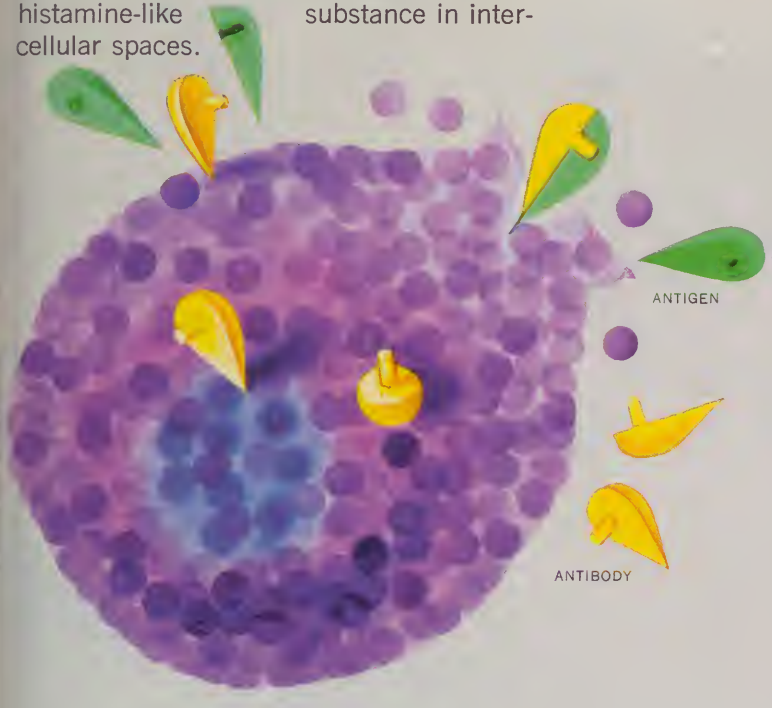
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REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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The Heart Page

George C. Roveti, MD—*Editor*

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ANTICOAGULANT THERAPY

ROBERT E. ENSOR, MD
Director of Anticoagulant Clinic
Mercy Hospital

Anticoagulant therapy has become popular in the last decade. By and large, most of the recent literature has been in its favor. The bleeding danger, while always present, has been repeatedly shown to be minimal.[1, 2]

The American Heart Association study, conducted by Wright[3] in 1948, has well established that the use of anticoagulants in acute myocardial infarction has a 50% improvement in mortality rate. There are a few clinicians, for instance Russek,[4] who would like to anticoagulate only the poor-risk cases. This is possible only in retrospect. The faith in these drugs in the United States has become so great that it is impossible to find a current control group without anticoagulants being administered. However, some researchers, mostly abroad, have doubted their value even in acute coronary thrombosis with infarction. The Copenhagen Study by Iversen and Hilden in 1961[5] failed to show significant improvement with their use.

In the long-term treatment of coronary disease, there have been many statistics reported in the last 10 years.[6] We reported a study of 521 patients from the Mercy Hospital Anticoagulant Clinic,[6] finding mortality rates after myocardial infarction at the five and ten year epochs with anticoagulants were 21% and 25%, respectively. Controls without anticoagulants repeatedly confirmed in the literature were 44% and 65%. respectively. Usually those in the literature who disagree do so because of small series or inadequate anticoagulant levels. Tullock and Gilchrist,[7] from England, have written one of the better dissenting articles. Another popular one has been the Copenhagen Study by Iversen and Hilden.[5] Their conclusions briefly were as follows:

> Despite many years' energetic efforts at clarifying the value of anticoagulants in coronary heart disease, it has not been possible to advance a decisive proof of the usefulness of this treatment. Therefore, it cannot at the present moment be considered medically unjustified to omit this therapy in any form of coronary heart disease. It is only during the first year of follow-up that the anticoagulant treated patients appear to fare better than the placebo treated ones, but the differences are not significant, except for the reinfarction rate in patients over 60 years of age.

I would like to point out, however, that they used Dicumarol in their studies, which in my opinion, is the poorest drug available in the last 10 years. Their main objection to previous studies such as our own was the lack of concurrent placebo treated cases or the use of controls from a previous era.

Anticoagulant therapy is also used in the treatment of acute and recurrent phlebitis, which makes up a large group of our clinic population. In former years, venous ligation of the leg veins was the most common method of trying to prevent recurrent emboli. In the last year or two, a change of mind has come about in the treatment of acute phlebothrombosis. To quote Henderson:[8]

> Today, most investigators agree that the treatment of choice is anticoagulant therapy, unless it has been tried and has failed, or unless a definite contraindication to its use is present.

In phlebothrombosis, calf tenderness, swelling, and positive Homan's sign are found, but usually no signs of redness along the superficial veins. In these cases, subcutaneous heparin therapy

should be instituted immediately along with one of the coumarin derivatives.

Anticoagulants in cerebral thrombosis have been advocated for years by Dr. Irving Wright from Cornell.[3] Intermittent carotid artery insufficiency or basilar artery insufficiency have 95% good results with anticoagulants.

Several other diseases which respond favorably to anticoagulants should be mentioned. Many cases of Leriche syndrome are being operated on. At Mercy Hospital we have 10 patients on anticoagulants who have never had surgery. These patients are now asymptomatic and have remained so for five years or more. Retinal venous thromboses also often improve with anticoagulants. Ophthalmologists refer many of these patients to the clinic.

The lytic agents came in and out of use rather rapidly. To quote Henderson,[8] "Although the early use of lytic agents should theoretically result in successful lysis of the embolus, it has been generally unrewarding." This has certainly been our experience. Fibrinolysin also has the hazard of serum hepatitis.

Phytonadione (Mephyton) has been a boon to anticoagulant therapy.[2, 1] Five or ten milligrams by mouth will generally neutralize therapy giving a normal prothrombin time in 6 to 12 hours. Of course, larger doses are necessary should an emergency exist. Intravenous K_1 oxide is associated with severe reactions at times and is rarely indicated. Intramuscular preparation is also available.

Various anticoagulant drugs have been used over the years. Bishydroxycoumarin (Dicumarol) was most widely used for years. Now there are many other much better drugs. Our drugs of choice are phenprocoumon (Liquamar) and Warfarin sodium (Coumadin), in that order. Either drug works well. Phenprocoumon is easier to use [2] because it keeps a stable level and doesn't drop as easily. About 1% of patients on these coumarins will develop a skin rash over a period of time. We then switch to another group of anticoagulant compounds, namely, the indandiones, eg, phenindione (Hedulin) or anisindione (Miradon).

Heparin has long been established as the ideal anticoagulant were it not for difficulty of management and cost. In case of severe, life-threatening, or urgent need for immediate anticoagulations, heparin can now be regulated quite easily by deep subcutaneous injection of concentrated aqueous heparin.

Finally, whereas anticoagulants do well on venous conditions, most of the debate over the years has been whether or not they definitely help in arterial disorders. The increase in popularity in the last 10 years has been mainly in arterial disease. Certainly some method of slowing arteriosclerotic lesions or possibly preventing them eventually will replace anticoagulants in arterial disease. Until then, anticoagulants are the best we have to offer for this condition.

GENERIC AND TRADE NAMES OF DRUGS

Anisindione—*Miradon*
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Heparin sodium—*Heparin Sodium, Liquaemin Sodium*
Phenindione—*Danilone, Eridone, Hedulin*
Phenprocoumon—*Liquamar*
Phytonadione—*Aqua Mephyton, Konakion, Mephyton, Mono-Kay*
Warfarin sodium—*Coumadin Sodium, Panwarfin, Prothromadin*

REFERENCES

1. Mead, A. W., and Wright, I. S.: Anticoagulant Therapy Today. *Med Clin N Amer* 45:907-914 (July) 1961.
2. Ensor, R. E., and Peters, H. R.: Experiences with the Anticoagulant Marcumar. *Ann Intern Med* 47:731 (Oct.) 1957.
3. Wright, I. S.; Marple, C. D.; and Beck, D. F.: *Myocardial Infarction.* New York: Grune & Stratton, 1954.
4. Russek, A. I., and Zohman, B. L.: Limited Use of Anticoagulants in Acute Myocardial Infarction. *JAMA* 163:922 (March 16) 1957.
5. Iversen, K., and Hilden, T.: The Use of Anticoagulants in Coronary Heart Disease. *Med Clin N. Amer* 46:1613 (Nov.) 1962.
6. Ensor, R. E., and Peters, H. R., Long-term Anticoagulant Therapy in Coronary Disease. *JAMA* 169: 914-918 (Feb. 28) 1959.
7. Tulloch, J. A., and Gilchrist, A. R.: Anticoagulants in Treatment of Coronary Thrombosis. *Brit Med J* 2:965, 1950.
8. Henderson, R. R.: Pulmonary Embolism and Infarction. *Med Clin N Amer* 48:1425 (Nov.) 1964.

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REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Follow-up in Chronic Diseases

DOUGLAS CARROLL, MD

MANY PATIENTS WITH CHRONIC DISEASES now occupying beds in both acute and chronic hospitals can be cared for just as well in the home, provided certain requirements are met. There is evidence that teams of nurses and doctors can carry on visiting programs to keep patients at home. There is increasing demand that patients be placed in the cheapest and most appropriate facility that will fulfill their needs adequately.

The readjustment that many patients with chronic diseases have to make on discharge from the hospital is sometimes as revolutionary as birth or puberty. There may be limitations in activity because of paralysis, angina, or loss of a limb; there may be barriers because of loss of mental functioning; there may be restrictions in social intercourse and vocational potential. In addition to these physical, mental, and social adjustments, patients must remain under medical supervision and follow certain directions if they are to continue well at home. An alarming number of patients do not follow directions given them by the physician, with the result that the benefits of their stay in the hospital are lost.[1] Poor follow-up constitutes a preventable waste in hospital usage and human suffering.

Most patients with chronic diseases being discharged from an acute hospital need continuing medical care. Indeed, patients are frequently discharged before the ideal time. Mnay patients and their families are unprepared to adapt to the greatly restricted mode of living and to follow the directions necessary to remain in health.

An excellent study by Donabedian and Rosenfeld [2] divided the follow-up services to the patient into categories:

1. Medical supervision (outpatient, house, or office visits)
2. Regimens (dietary modification, oral medications, self administered injections, or regulation of daily activities)
3. Nursing services (injections, dressings, bedside care, and observation)
4. Rehabilitation services
5. Dental services
6. Social services
7. Institutional care

Ninety-nine per cent of the patients were discharged with a recommendation for medical supervision or a regimen. Twenty-one per cent of the group did not comply with the medical supervision recommendation, and 33% did not comply with the regimen recommendation. More than half of the patients did not comply with one or more of the recommendations made.

Some of the reasons why patients do not follow directions are:

1. Faulty judgment on the part of the physician.—The physician must decide whether the patient is well enough to go home and whether the family has the required time, understanding, and responsibility to carry out directions. The physician must anticipate the patient's needs in follow-up services and be certain that they are available. The clearer and simpler the physician's

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plan for the patient, the more likely it is to be carried out.

2. Faulty communication between patient and physician.—If the physician is to direct the patient or his family realistically, he must have a grasp not only of the patient's disease, psychosomatic problems, and physical independence but also of the financial, familial, and domiciliary arrangements. With this information, he may make a tentative plan. He will be unable to communicate the plan, however, if he does not attempt to see it through the patient's eyes. He must try to enter into the patient's place and see the plan as the patient does, being sure that words mean the same to the patient as to himself. Only by identifying with the patient and listening to his questions and objections can a good plan be developed. Dialogue rather than a monologue is essential to communication.

3. Faulty execution.—Provided the plan is a good one and communication between the physician and patient has been successful, the patient or family may still be unable to carry it through. The family may find itself unable to supply the help it promised. Community resources may be insufficient to care for the patient's needs. The family or patient may lose interest in making the plan work.

The ultimate responsibility of the long-term care and supervision of the patient must rest with the patient's personal physician. As medicine becomes more complex, more and more paramedical tasks are placed on the personal physician. It is almost impossible for the physician to give personal attention to the multiple details and integration of the care of large numbers of chronic patients. Few physicians have the time to do it well; that they can do it at all is surprising.

If the present chaos in carrying out recommendations is to be overcome, a number of questions will have to be answered:

1. Are the recommendations given by physicians too elaborate? How many are really essential?
2. How can communication between physician and patient be improved?
3. What is the place of the home visit team led by a physician, including laboratory, x-ray, electrocardiographic technicians, visiting nurses, physical and occupational therapists, and social workers? How should such teams be organized and paid. What would be their relationship to the private practitioner? [3-5]
4. How can the medical needs of patients in nursing homes be met more adequately? [6]
5. How can the community resources be developed and mobilized to meet the problems of the chronically ill? [7]

REFERENCES

1. Davis, M. S., and Eichhorn, R. L.: Compliance With Medical Regimens: A Panel Study. *J Health Hum Behav* 4:240, 1963.
2. Donabedian, A., and Rosenfeld, L. S.: Follow-up Study of Chronically Ill Patients Discharged from Hospital. *J Chron Dis* 17:847, 1964.
3. Entwisle, G.: *Home Care Project.* Dept. of Preventive Medicine and Rehabilitation, University of Maryland, School of Medicine, 1964.
4. Ferguson, T., and MacPhail, A. N.: *Hospital and Community.* Oxford Univ Press, 1954.
5. *Comprehensive Medical Rehabilitation Programs for Maryland.* Committee on Medical Care, Subcommittee on Chronic Illness, Maryland State Planning Commission, Aug, 1961.
6. *A Study of Nursing Home Care in Maryland.* Bureau of Medical Services and Hospitals, Maryland State Department of Health. Oct, 1960.
7. Allan, W. S.: *Rehabilitation, a Community Challenge.* John Wiley and Sons, Inc., New York, 1958.

Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Prevention of Alcoholism

ALCOHOLISM PREVENTION BY INDIVIDUAL PHYSICIANS

WILLIAM B. TERHUNE, MD
Medical Director, The Silver Hill Foundation

As a general measure, all physicians should teach all their patients that good habits of living—work, rest, exercise (particularly exercise), and play—dissipate or absorb emotional stress. Therefore, if one feels the need of a drink, he should try walking instead—for hours, if necessary! Physicians can show people how to live less stressfully by simplifying their lives and following a balanced schedule. Physicians can teach a sound philosophy of life, one that is realistic, strong, positive, and purposeful, and can demonstrate that all problems must be decided in terms of one's life purpose. If a person has no life purpose, he must find one. A personal philosophy and a practical religion enable man to navigate the turbulent seas of life. The variant emotional gales are strong, and the sudden explosive attacks of aggression and the force of buried hostility can destroy. But these shoals can be avoided and the storms weathered if one has stability of direction and a purposeful life, guided toward ideals.

Instruction in Ten Commandments to Prevent Alcoholism.—Physicians should instruct their patients to follow these ten rules to avoid the development of alcohol dependency:

1. Never take a drink when you "need" one.

2. Sip slowly and space your drinks: the second drink thirty minutes after the first; the third an hour after the second; and never a fourth.

3. Dilute alcohol. Have a long, weak drink—never on the rocks, never straight, and never, never out of the bottle!

4. Keep an accurate and truthful record of the amount and number of drinks you take. Never take a drink every day. Be vigilant and alert about the amount of each drink, whether you mix it or your host does. Does it consist of 1, 2, or 3 ounces of alcohol, or was it poured without measure—"just a wee drop"?

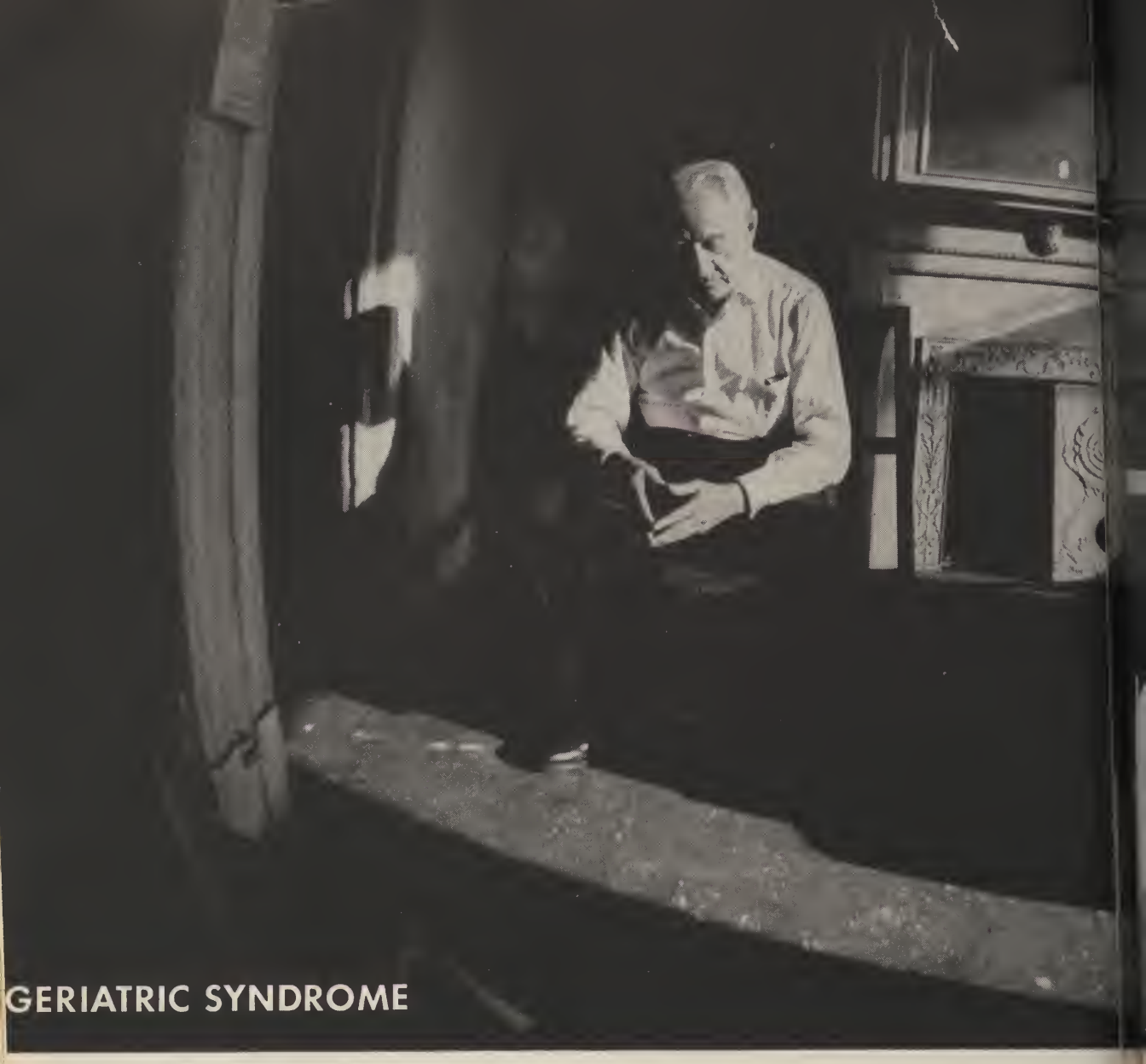
5. Never conceal the amount of alcohol you drink. Instead, exaggerate it. If you say you drink twice as much as you think you do, this will probably be nearly accurate.

6. Do not drink on an empty stomach.

7. Stop drinking on signal. The signals are "luncheon," "left office," "on the way home," "before dinner," "before bed," "meeting people," "celebrating," and "to get me through." Substitute something in place of alcohol at these times, such as a big cup of hot, strong tea before dinner to refresh and energize (mountain climbers drink tea, not alcohol); a bowl of hot bouillon before lunch in place of a Martini; a cup of hot Ovaltine at bedtime; and the habitual drinking of water. If one uses these beverages as alcohol substitutes, he will feel better, be a better companion, and enjoy happier evenings. The use of some of these measures will interrupt the habit of "signal drinking."

8. When tired or tense, soak in a hot tub and follow with a cold shower.

An excerpt from an article, "Prevention of Alcoholism: How to Drink and Stay Sober," published in the *New York State Journal of Medicine*, 64:16 (Aug. 15) 1964. Reprinted by permission of author and editor.



when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

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9. Never take a drink to escape discomfort, either physical or mental.

10. Never, never take a drink in the morning, thinking it will offset a hangover.

Avoid alcohol dependency as you would the plague. It is most insidious and unless you are very careful, it will steal up without you knowing it. A person is on his way to alcoholism when alcohol has an effect on him that is stronger than usual; when he takes a drink as "medicine"; when he drinks compulsively (has to have a drink); and when he drinks when he knows he should not.

When a person's body chemistry and psychologic reactions become alcoholic, he has "had" it. If he continues drinking at all, he will become either alcohol dependent or a true alcoholic. Once a person repeatedly becomes inebriated he will never again under any circumstances be able to use alcohol safely no matter how small the amount, because one drink will demand another.

To sum up what has been said so far about measures the individual physician can take to prevent alcoholism:

1. Each physician should investigate and record the alcohol habits of all patients and follow them up each time they return for consultation. Most people would be shocked if they marked on a calendar each day every drink they took. Even for one month the total would amaze them. All people have a protective amnesia about how much they drink.

2. He should tell patients the facts about the use of alchohol and teach them individually how to drink safely.

3. He should recognize the alcohol-prone personality and secure psychiatric guidance for such people before alcohol becomes a further complication to an already, often increasingly inefficient personality. Persuade neurotic patients to seek help before they become alcohol dependent.

4. He should give all patients a printed copy of "The Ten Commandments for Safe and Happy Drinking," and reiterate that even one drink never made a person more attractive; it merely puts his self-critical faculty to sleep.

ALCOHOLISM PREVENTION BY MEDICAL PROFESSION

The medical profession as a whole should take the following steps to aid in the goal of alcoholism prevention. They should:

1. Make a public statement to the effect that alcohol is a poor and dangerous medicine.

2. Adopt and widely circulate resolutions outlining the nature of alcohol dependency and stating it is a malignant condition when once developed. Call on individuals, government, and all public agencies to make positive efforts to interrupt the process.

3. Clean their own house by outlawing the practice whereby pharmaceutical concerns and other business organizations underwrite medical convention cocktail parties or operate hospitality rooms. Further, medical program committees and governing boards of medical societies should frown on the ubiquitous cocktail parties that are a part of most medical conventions. If physicians and their wives wish to invite their friends for cocktails, the program committee and the business manager of the association should have no part in it, and notes regarding parties or reunions should not be printed in the programs or announced on the bulletin board.

4. Dedicate itself to the prevention of alcoholism and appoint active committees charged with the responsibility of alcoholism prevention.



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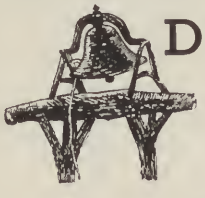
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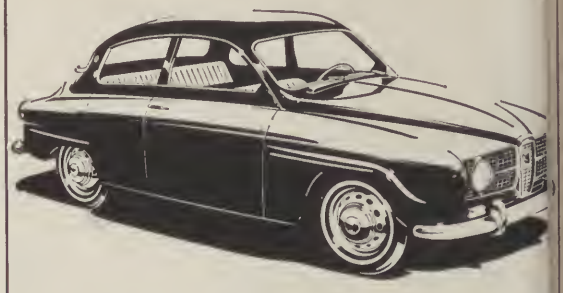
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Towson YMCA Program for Handicapped Children

The Adventurers Club and Camp Discovery

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In November, 1964 a new program, the Adventurers Club, was initiated at the Towson YMCA for physically and mentally handicapped children. A diversified recreation program, the Adventurers developed from a Saturday morning swimming class for handicapped children. During these sessions, the children showed such enthusiasm playing and learning together that it was decided to expand the lessons to include arts and crafts, games, tumbling, and other special activities. Now the Adventurers meet on Saturdays, from 9 to 11 AM, in sessions of 10 weeks each throughout the school year.

With this new program the staff has increased to a ratio of one counselor for every four children. During the 45-minute swimming period, children are grouped according to their particular developmental ability and interest level. Basic swimming techniques are taught with particular emphasis on relaxation in the water, exercises for proper coordination and breathing, and water play. Swimming is one of the most important activities in the club because of the benefits to handicapped children: recreational activity is offered without competition; the learner is able to experience success on his own level, resulting in a feeling of satisfaction and increased confidence; participation may motivate the child to attempt other activities. Success in swimming and the desire to continue improvement may result in a lengthened span of attention. Overcoming a fear of the water or apprehension concerning it may inspire confidence to overcome other fears.

Other physical activities of the club include tumbling, hiking, and group games. Basic tumbling skills are taught as "funny stunts," with children imitating the teacher. This activity is designed to improve coordination, balance, and concentration. Because tumbling is an individual skill, taking turns is necessary and learning patience and cooperation is encouraged. The spring session includes rebound tumbling, with particular emphasis on balance and muscular coordination. Even though each participant may be on a different developmental level, group gymnastics are extremely important in the program.

Outdoor activities are truly adventures for staff and children alike. Most of the children are curious and enthusiastic about nature. Excursions are conducted often. Sometimes the entire group hikes and plays games. On other occasions a leader and several children investigate the grounds and woods together. Favorable response to this part of the program has led to plans for an overnight trip to a nearby camp during the spring session.

Group games are selected carefully to suit the needs of all Adventurers. At times this presents problems because, to some, forming a circle or lining up is a struggle, especially for those not in school. Once organized, however, games are enjoyed and favorites are repeated week after week. Game situations allow leaders to observe children as to their distractibility, hyperactivity, and irritability in a social situation.

All the children participate in arts and crafts.

Some show true talent and dexterity, and all become thoroughly engrossed while working. Each child works independently. To insure a sense of accomplishment, crafts are designed to give rapid, pleasing results.

Leaders in the program comprise both paid and volunteer workers. The entire staff realizes that diversified recreation activity provided for these children during their formative years leads to beneficial growth in areas of social competence, muscular coordination, and motivation. Also, children participating in purposeful recreational activities attain a higher degree of intellectual development than those who are inactive and lack direction. When working with special children, one must realize that they are like other children in many of their needs—the need for new experiences, for belonging, for friends, for social approval, and for self respect. Unlike others, however, handicapped children are often faced with frustrations which may cause greater maladjustments than could be attributed to their basic handicap. With this in mind, the goal is to help them to achieve more complete fulfillment in the areas of personal and social competence.

How do the leaders determine an individual's needs? By observing the children in try-out experiences and from information supplied by parents, teachers, and others. Every effort is made to accommodate each child according to his needs.

The Adventurers Club is planned—but flexible. For example, those showing special interest in arts and crafts are allowed to pursue projects which may differ from or take more time than those planned. Flexibility is encouraged because special interests are usually a healthy indication of initiative and imagination. Planning and routine are just as important as flexibility, since a sense of security is gained when a definite direction is evident at all times.

In all situations attention is focused on the child what he can do and what is best for him in terms of activities provided. The greatest responsibility is to encourage the Adventurers to develop self-confidence and self-direction through constructive enjoyable use of leisure time. Inquiries can be made at the Towson YMCA, Monday through Saturday, 9 AM through 10 PM, by calling 823-8870.

CAMP DISCOVERY

Camp Discovery is the new summer day camp for children needing special attention. Sessions will run for three two-week periods, beginning July 6 and ending August 13. The program will be in session Monday through Friday from 9 AM to 4:30 PM. Transportation will be provided from the Towson YMCA each morning, returning the children each evening. Parents are asked to deliver and pick up their children each day. The fee for each two-week session is $40, which includes insurance, milk, and transportation. Children are asked to bring lunch and a swimming suit each day. Each session is limited to 20 children age 5 to 15. Acceptance is on a first come, first served basis subject to approval of the director.

Located in Randallstown, Camp Discovery will offer a wide range of outdoor activities. Swimming lessons for two hours each day with competent instructors will make this time one of therapy and recreation as well as practical instruction. Camp crafts include basket weaving, leathercraft, and woodwork. Hiking, camp-outs, cook-outs, and field trips will help children discover the wonders of nature and joys of outdoor living.

One counselor will be provided for every five children in order to create a relaxed, personal atmosphere with emphasis on individual needs and abilities. A camp is only as good as its counselors. With this in mind, the entire staff strives to offer the patience and understanding necessary for a successful program for handicapped children. A healthy combination of learning and laughter throughout the summer in all activities will be the goal of all.

Additional information can be obtained by calling the Towson YMCA or Mrs. Bonnie Brandt at 235-3129.

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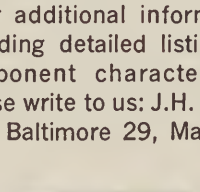
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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JOHN WHITRIDGE, JR., MD, chairman

Case 1: Eclampsia

This patient was a 25-year-old primigravida whose estimated date of confinement was June 20. She made her first prenatal visit on February 20, at which time the blood pressure was 120/80, urine was negative for albumin and sugar, and her weight was 138 lb. The fundus was 2 cm below the umbilicus, and the patient said she had been feeling fetal movements for the past few weeks. The other physical findings were essentially normal.

The patient did not make another prenatal visit until April 29, at which time the urine was still negative, weight was 142½ lb, there was no edema, and the blood pressure was 140/80. The fetal heart was easily audible. Her next prenatal visit was on May 21; her weight was 153 lb, blood pressure 140/80, urine negative for albumin, and there was 2+ peripheral edema. Hydrodiuril, 50 mgm bid, was prescribed, and she was told to return in one week.

One week later, on May 28, the blood pressure had fallen to 110/80, the patient had lost 10 lb, the weight being 143 lb, and there was no peripheral edema. Fetal heart was normal. The patient was not seen or heard from again until 2 PM on June 26, when her husband called the attending physician to say that the membranes had ruptured and she was beginning in early labor. The husband was instructed to take her immediately to the hospital.

On admission, at 3:30 PM, while she was being given an enema, the patient had a severe, prolonged, generalized convulsion. The blood pressure on admission had been 180/120 and there had been 3+ peripheral edema. Her convulsive seizure lasted for approximately 30 minutes. When seen by her attending physician at 4:30 PM, she was still having convulsions.

While her physician was en route to the hospital, another physician present ordered intramuscular Seconal. Her own physician administered 2.5 mgm of Serpasil intramuscularly and 100 mgm of sodium pentobarbital intravenously. Her condition continued unchanged. She had repeated convulsions and was therefore given 1 mgm of Unitensen in 20 cc of 10% glucose in water. Blood pressure suddenly fell to 110/80 and convulsions ceased.

Rectal examination at this time revealed the cervix to be 5 cm dilated, 80% effaced, with the head low in the pelvis. Fetal heart sounds were questionable. She was taken to the delivery room and a pitocin drip of one ampoule of pitocin in 1000 cc of 10% glucose in water was started at the rate of 16 drops per minute.

At 6:30 PM she was delivered spontaneously over a small median episiotomy, under pudendal block, of a stillborn male infant weighing 7 lb 7 oz. She had received approximately 100 cc of the pitocin drip. The placenta was delivered spontaneously with a total estimated blood loss of approximately 750 cc. She received one ampoule of methergine and there was no further unusual vaginal bleeding.

For the first 90 minutes after delivery her blood pressure ranged between 100/60 and 110/80. During this time she was receiving 10% glucose in water intravenously. At 11:30 PM the blood pressure had risen to 140/90 and at midnight

Identifying data have been omitted and times and dates have been altered to preserve confidentiality of information.

reached 150/100, at which time the patient had another seizure lasting approximately one minute. She received 100 mgm of sodium pentobarbital and 2.5 mgm of Serpasil intramuscularly. She was seen by a consultant, who suggested that intramuscular magnesium sulfate be given. Accordingly, 4 gm of 50% magnesium sulfate was administered intramuscularly, to be followed by 2 gm every four hours. An indwelling catheter was inserted and a small amount of dark brown urine obtained which contained 4+ albumin.

Shortly after 4 AM the pressure began to fall and varied between 90/50 and 80/40. All medications were stopped. By this time she had received 6 gm of magnesium sulfate; 10% glucose in water was continued intravenously. At 9 AM the blood pressure was 60/0 and intravenous blood plasma was begun. There was no evidence of pulmonary edema, and the pulse rate was 60 per minute and steady. While preparations were being made for a slow intravenous levophed drip, respirations ceased and the patient was pronounced dead at 11:40 AM.

On postmortem examination the positive findings were as follows: *Kidneys*—glomerular ischemia and capsular thickening. *Liver*—peripheral hemorrhage and necrosis. *Brain*—cerebral edema, subarachnoid hemorrhage, mild; congestion of pituitary gland; and cerebral contusion. *Cause of death*—eclampsia.

COMMENTS

On review of this case, the committee felt that this was obviously a maternal death and that the cause of death as listed, namely, eclampsia, was correct. The committee members further voted this as a preventable death on the basis of inadequate prenatal care, with the responsibility presumably the patient's for having failed to follow prenatal instructions. This patient had already demonstrated definite evidences of pre-eclampsia, with borderline blood pressure, weight gain due to retained fluids, and a dramatic response to therapy with the loss of 10 lb in one week.

The committee also expressed the feeling that too many different medications were given in an effort to control her convulsions and hypertension. Within a short space of time she received Seconal, Serpasil, sodium pentobarbital, Unitensen, and magnesium sulfate. There is, of course, no assurance that once convulsions had begun any other regime would have necessarily altered the outcome. The committee thought, however, that better control and stabilization can be achieved through the use of one or, at most, two anticonvulsive hypotensive agents.

Secondly, the committee questioned the wisdom of the use of a pitocin drip. The patient was already 5 cm dilated, apparently in active labor, and with a presumably dead fetus. Hurrying to empty the uterus at this juncture seems less important than control of blood pressure and the eclampsia.



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New Appointments

DR. SWALLOW—PEDIATRICS

Kathleen A. Swallow, MD, has been appointed chief pediatrician in the Baltimore Maternity and Infant Center, 211 W Lombard St. She will set up special services related to the care of babies born of mothers whose condition may have an adverse effect on the health of the baby.

Dr. Swallow, a native of Canada, received her undergraduate and medical education at the University of Alberta and the Master of Public Health degree from The Johns Hopkins School of Hygiene and Public Health. Postgraduate training in pediatrics was received at the University of Alberta and at the Toronto General Hospital and the Hospital for Sick Children in Toronto. Dr. Swallow has served in the Royal Canadian Medical Corps and has engaged in research and clinical work at Harvard University Medical School and the Massachusetts General Hospital.

Before coming to Baltimore she was an associate professor of pediatrics at the University of Alberta. In February she was appointed assistant professor of pediatrics at The Johns Hopkins University School of Medicine and will continue that affiliation.

DR. MOODIE—TUBERCULOSIS

Allan S. Moodie, MD, is the City Health Department's new administrative health officer for tuberculosis control. After a period of study of Baltimore's tuberculosis program, Dr. Moodie will implement various recommendations toward further control of this public health problem.

Dr. Moodie is highly qualified for this work in view of almost 30 years experience in this field. A graduate in medicine of Glasgow University in 1936, Dr. Moodie has practiced general medicine in various hospitals in Great Britain, later specializing in tuberculosis. He received his diploma in public health from Glasgow University in 1939.

During World War II, Dr. Moodie was a health officer in West Cumberland and Lincoln, England. In 1945 he was appointed a medical officer in the British army and attained the rank of major —hygiene specialist. His service in this post included work with the civil affairs unit in Hong Kong and Singapore. In 1948 he was assigned to the Colonial Medical Service in Hong Kong and became director of a newly formed tuberculosis service there. His work in this position earned the royal award, Officer of the Order of the British Empire.

Dr. Moodie is a corresponding member of the National Tuberculosis Association, Fellow Emeritus of the American College of Chest Physicians, and a member of the Expert Advisory Panel on Tuberculosis for the World Health Organization.

DR. TAYBACK—CONSULTANT TO CHILDREN'S BUREAU

Matthew Tayback, ScD, deputy commissioner of health in the Baltimore City Health Department, has been appointed consultant to the Children's Bureau of the U.S. Department of Health, Education and Welfare. In this capacity he will help advise the Children's Bureau on a new and important program of research grants for advancing knowledge on problems of maternal and child health and on crippled children's services.

This new program of research grants was authorized by Congress in 1964 and is designed to encourage new methods by which existing scientific and medical information can be brought to bear on causes of serious disability among children.

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Highlights

INFECTIOUS HEPATITIS

Infectious hepatitis has been unusually prevalent in Crisfield and Hagerstown during the past fall and winter. In Crisfield, 80% of the 73 cases were in preschool and school children. Eighty cases have come to the attention of the health department in Hagerstown; 95% have been school children. Twenty-eight cases were reported during the past year in one of the state hospitals. Gamma globulin has been freely used, especially in the hospital and Hagerstown. In each of these communities the outbreaks are on the wane.

MEASLES VACCINATION

The Division of Epidemiology is actively promoting the use of the attenuated measles live virus vaccine by physicians and in the routine primary immunization programs carried out by local health departments. Although this is still one of the expensive vaccines, the price has recently been cut by half, and it is now possible for health departments to begin vaccinating children between 12 months and nine years who give no history of measles.

MEDICAL SELF-HELP TRAINING FILMS

A series of teaching films to be used in the medical self-help training program was received recently by the Office of Health Mobilization. The 11 films, each covering a subject area of the medical self-help course, were produced by the Public Health Service and are intended to supplement the course material found in the self-help training kit. The primary purpose of these films is to expand the scope of courses, enabling larger numbers of students to be taught in a much more effective manner.

FIRE AT LABORATORY LOCATION

Sections of the Bureau of Laboratories operating the cancer cytology, blood grouping, and hematology units were located in the rented basements of two North Charles Street row houses that were severely damaged by fire recently. The next day (Sunday), laboratory personnel were able to move out the apparatus and specimens and set up shop in various parts of the adjacent main building of the Bureau. By Monday afternoon, all of these laboratory units were issuing reports, though at a reduced rate of speed. Unfortunately, the determination of these workers to keep up the output of laboratory results does not offset the major setback in laboratory facilities caused by this catastrophe.

HOSPITAL CONSTRUCTION FUNDS IN DEMAND

Plans to construct hospitals have been stimulated by the State Hospital Loan Program (1964 legislation), with the result that competition has been intensified for available federal funds. Funds for fiscal year 1965 are committed, and applications are pending which will absorb fiscal year 1966 funds when they become available.

PROGRESS IN NURSING HOME CONSTRUCTION

After a slow start, nursing home construction under the state and federal construction program is making satisfactory progress: 1) A nursing home is under construction in St. Mary's County. 2) Bids are being taken on a nursing home to be constructed in Salisbury. 3) Drawings are complete and bids will be taken at an early date on a nursing home to be built in Havre de Grace. 4) Plans for a nursing home to be built in Crisfield are progressing. 5) In Cumberland a drive is being organized to raise the local share of funds for the construction of a nursing home.

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Department of Mental Hygiene

Diagnostic Admission Trends

LAST YEAR, FOR THE THIRD YEAR in a row, more patients were admitted to Maryland's psychiatric hospitals for the treatment of alcoholism than for any other single diagnosis. Nearly one out of every three admissions received a primary diagnosis of alcoholism.

As indicated in the table, in recent years there has been a pronounced upswing in the number and per cent of admissions diagnosed as alcoholic, as other personality disorders, or as psychoneurotic reactions. At the same time, there has been a proportional decline in admissions diagnosed as schizophrenia or with other psychotic disorders.

An analysis of these data indicates that:

1. The proportion of all admissions with a diagnosis of alcoholism is increasing. In actual numbers, alcoholic admissions have more than doubled since 1960. In addition, a substantial number of admissions with other diagnoses are reported to have a major drinking problem.

2. The proportion of all patients admitted with a primary diagnosis of schizophrenia or other psychotic disorders is decreasing. Among admissions with no previous hospitalization experience, less than one out of every four are now reported to be psychotic.

3. One out of every 10 admissions has a diagnosis related to disorders of old age. The number of these admissions has not changed appreciably in recent years.

4. The number of admissions diagnosed as retarded is increasing. Last year, for the first time, this nearly equaled the number of patients admitted to Rosewood, Maryland's hospital for the mentally retarded.

Most patients with alcoholism or other personality disorders are hospitalized for short term active treatment services. Because of this greater turnover, they occupy only a small proportion of all hospital beds. The majority of beds continue to be occupied by chronic psychotic, geriatric, and other long term patients.

Kurt Gorwitz

Reported Primary Diagnosis	Percent Of Admissions During Year 1964	1963	1962
Alcoholism	31.2	30.4	28.6
Other personality disorders	8.3	7.0	6.2
Psychoneurotic reactions	7.9	7.7	6.8
Schizophrenia	24.0	26.7	27.8
Other psychotic disorders	5.4	5.4	5.7
Disorders related to old age	10.0	10.6	11.7
Mental retardation	2.6	2.3	2.5
All others	10.6	9.9	10.7
Total admissions	7,871	7,257	6,221



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Woman's Auxiliary

MAY, 1965

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

MRS. MARTIN E. STROBEL PRESIDENT 1965-1966



THE Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland is fortunate to have at its helm this year a capable, energetic, and dedicated woman.

Norma Strobel was born in Baltimore and is a graduate of Western Maryland College. It was here that she met her husband-to-be. They were both members of the Beta Beta Beta National Biological Fraternity, which held a regional conference at Western Maryland while Dr. Strobel was a first year medical student.

After her graduation in 1939 until 1943, Norma was secretary to Dr. Maxwell Wintrobe, who was professor of hematology, and Dr. Alan Chesney, dean of the Johns Hopkins University School of Medicine. From 1955 to 1962, she taught French in the lower school of the Hannah More Academy.

Norma was a member of the board of directors of the Patrons Club of McDonogh School from 1961 to 1964. She has been active in the Woman's Club of Glyndon since 1948 and has held numerous offices, including that of president. She is also a charter member of the Woman's Auxiliary to Carroll County General Hospital and is first vice president of this group.

A family of three children has not kept Norma from active participation in the Woman's Auxiliary to the Baltimore County Medical Association. Susan, 20, is attending Gettysburg College; Kent, 18, is at Citadel College, in South Carolina; and Ellen, 13, is at Garrison Junior High School.

Norma was president of the Woman's Auxiliary to the Baltimore County Medical Association in 1952. She has also served as chairman of the Health Careers Committee, Revisions Committee, Program Committee, and Legislation Committee. In the state auxiliary she has been a vice president and AMA-ERF chairman.

We are looking forward to a successful and productive year.

DOCTOR'S DAY IN MONTGOMERY COUNTY

THE WOMAN'S Auxiliary to the Montgomery County Medical Society honored the doctors of Montgomery County at a reception and dinner dance at the Sheraton-Silver Spring Motor Inn on March 28. In addition, bouquets of red carnations, the official Doctor's Day flower, were placed in the four county hospitals by the members of the Woman's Auxiliary in tribute to our doctors.

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5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
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Mrs. William T. Joyce and Mrs. Norma Oliver were co-chairmen of the affair.

March 30 is proclaimed Doctor's Day each year in public tribute to all physicians, as it was on this day in 1842 that ether was first used as an anesthetic agent in a surgical operation, thereby providing mankind with the blessedness of freedom from pain and suffering during surgery. Now almost every state in the nation observes this occasion to honor members of the medical profession, both living and dead, with some act of kindness, gift, or tribute.

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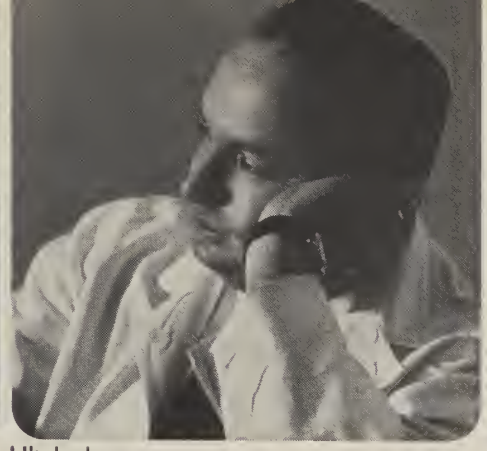
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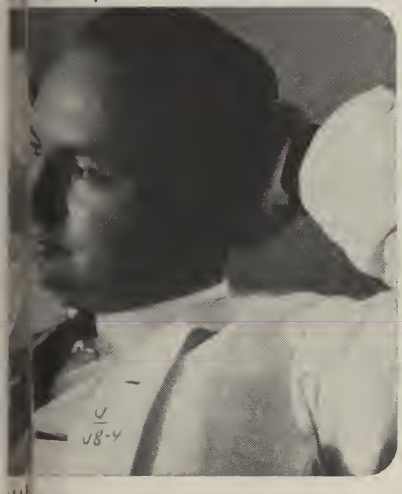
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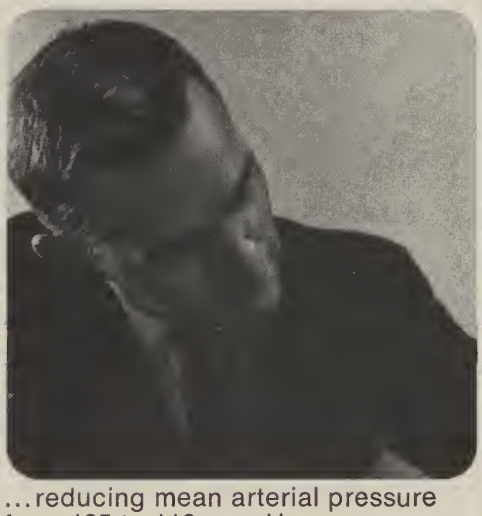


Uh-huh.

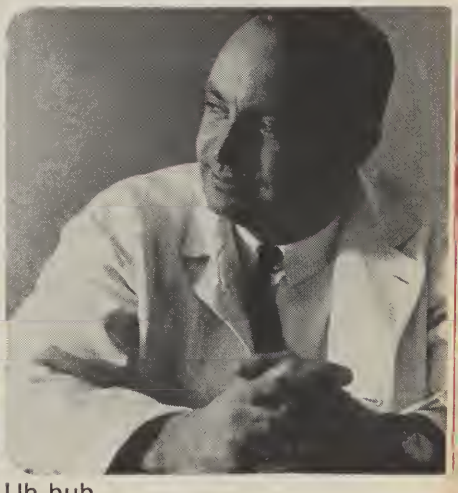


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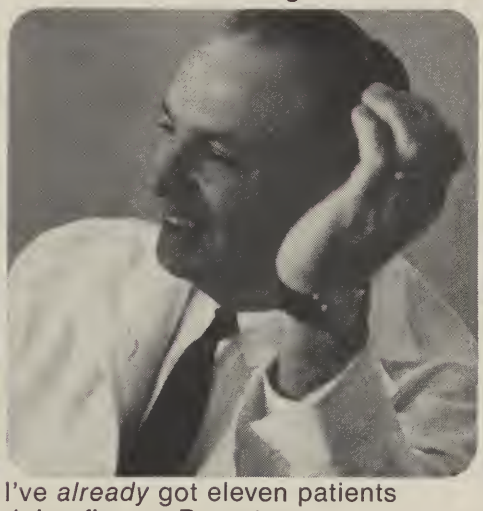
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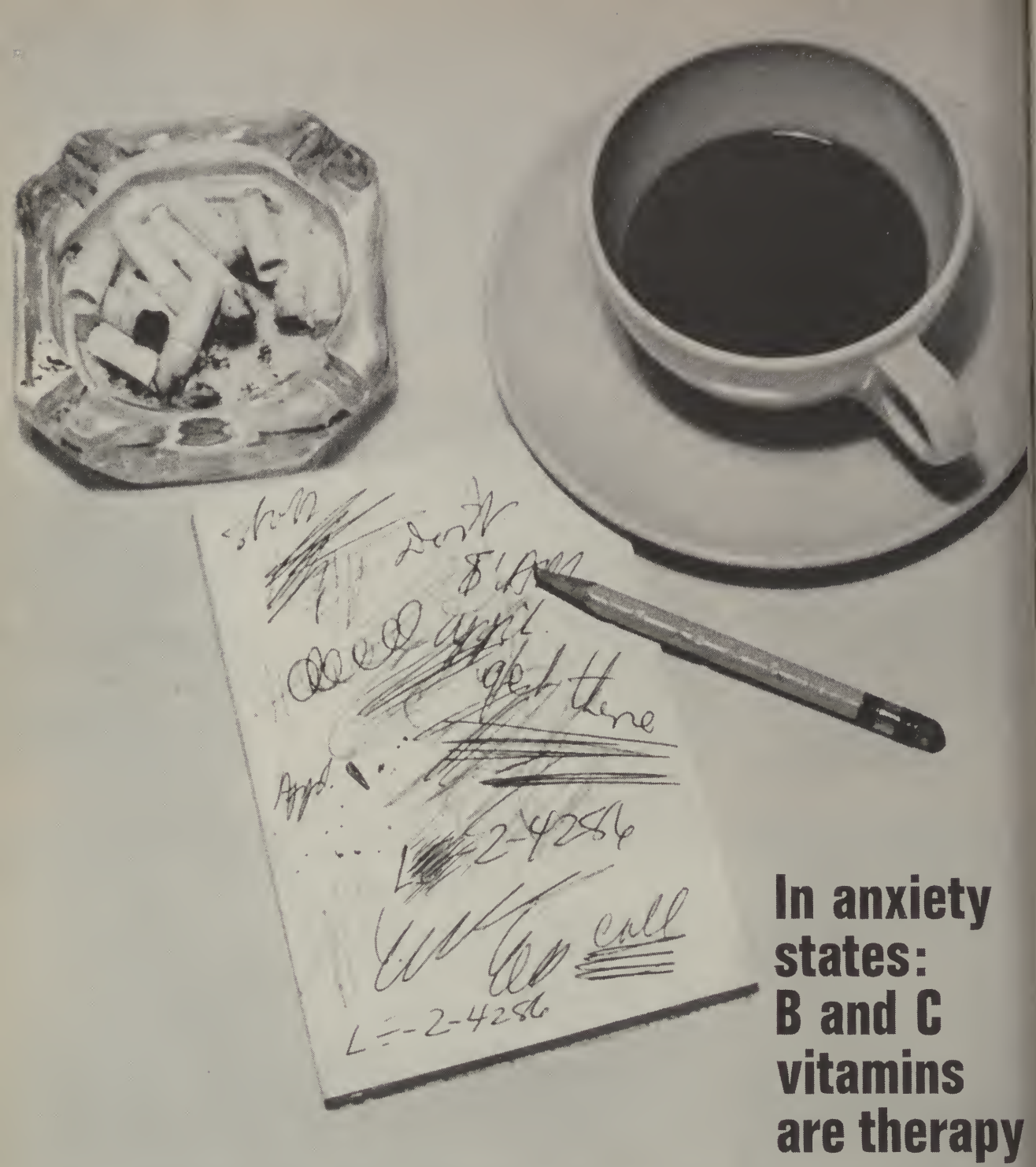
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Chapter VII. Sections-Section 7. Participation in Business Only *active members* registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the *business deliberation* of a section.

Please Note

An Active physician member may not *change his Section* registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days (by April 20, 1965) in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

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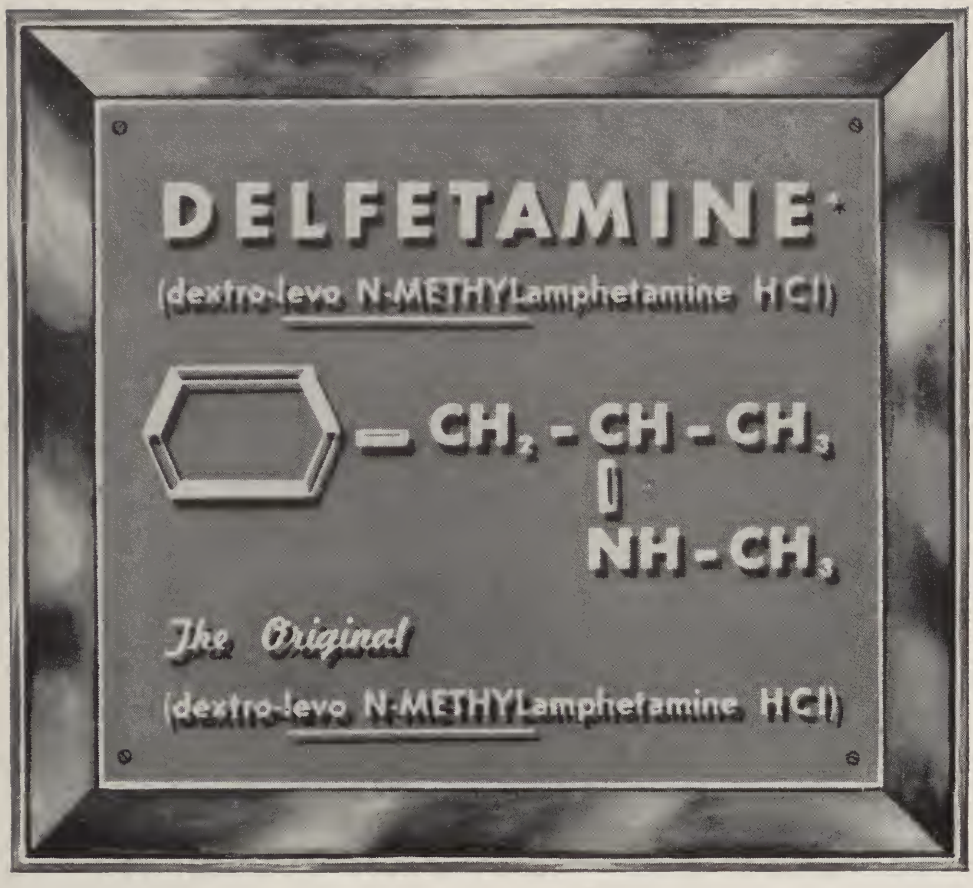
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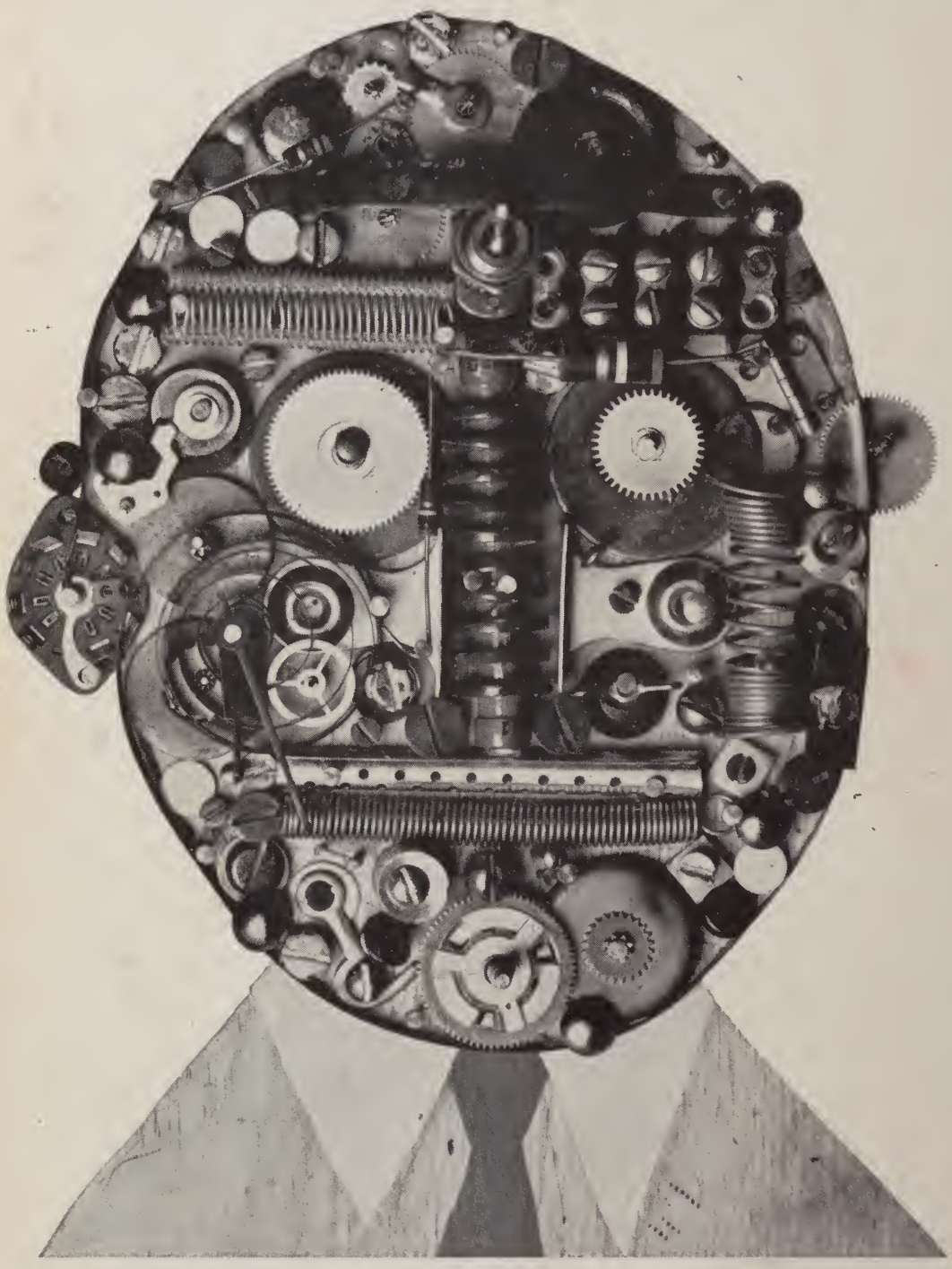
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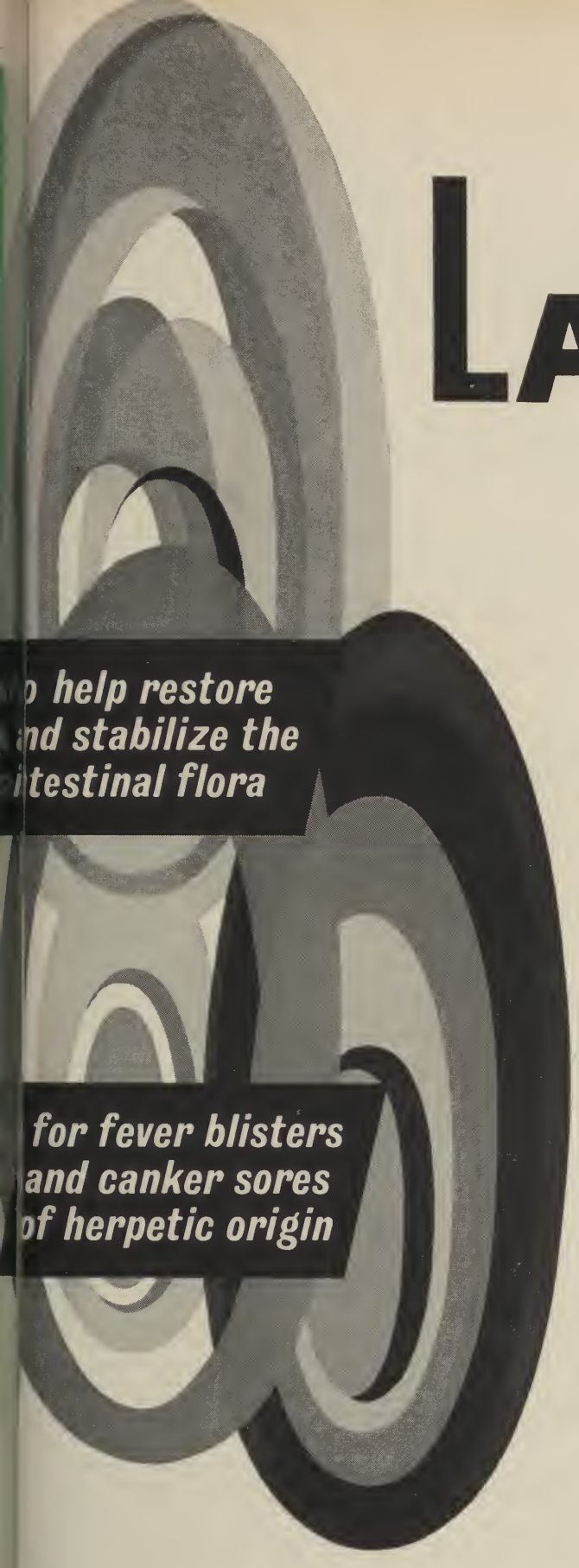
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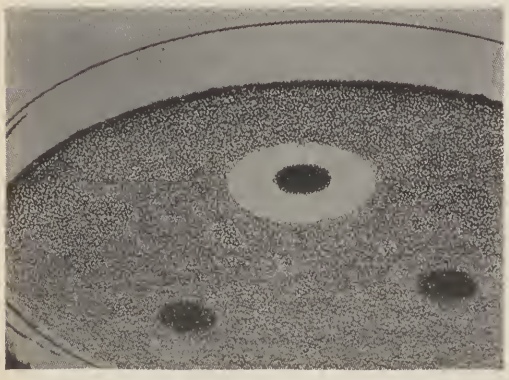
(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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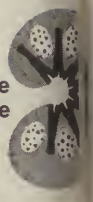
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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Maryland
STATE MEDICAL JOURNAL

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Vol. 14 No. 6
June 1965

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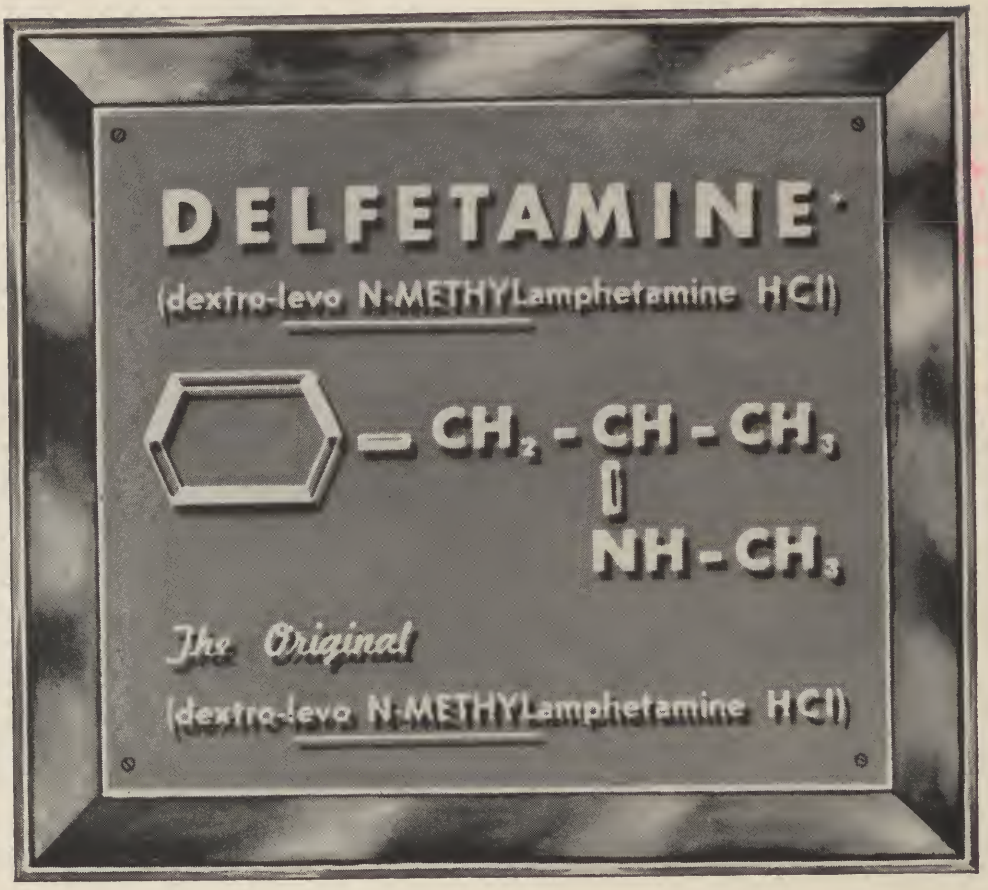
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EXECUTIVE SECRETARY'S NEWSLETTER

June, 1965

BLUE SHIELD TO PAY PODIATRISTS

The Court of Appeals has upheld the lower court decisions with respect to payment by Blue Shield of Podiatrists. The decision was based on the legislative fiat requiring Blue Shield to pay for services covered in its contracts which Podiatrists may perform under the Podiatry laws of Maryland.

WELCOME BACK

Advertisers returning to the pages of the Maryland State Medical Journal include Lakeside Laboratories, Milwaukee, Wisconsin; the Stuart Company, Pasadena, California; and E. Fougera and Company, Long Island, New York.

MENTAL HEALTH CONFERENCE

Mentioned in Smith, Kline and French's Psychiatric Reporter, May-June issue, is the Ocean City discussion on Blue-Collar Mental Health. This was held in October, 1964.

PLEASE RETURN POSTAL CARDS

In an attempt to make the Annual Directory issue of the Journal more useful to members and others, a reply, postage-paid card has been sent to all Faculty members.

PLEASE COMPLETE AND RETURN THIS CARD PROMPTLY. Failure to do so may result in omission of your name from the Directory Issue; or at best, incomplete data on your present appointments, certifications, etc.

RESOLUTIONS AND REFERENCE COMMITTEE DATE

Resolutions for consideration at the Semiannual Meeting of the House of Delegates must be received in the Faculty Office by

FRIDAY, JULY 16, 1965.

No meeting date has been set for the Reference Committee as yet.

NEWS NOTES

James A. Meyer, M.D., Silver Spring, and Merrill E. Parelhoff, M.D., Baltimore, have been certified as Fellows of the American College of Anesthesiology.

John W. Clark, M.D., Hagerstown, has been certified in Plastic and Reconstructive Surgery.

NEWS NOTES (cont'd)

B. O. Thomas, M.D., was honored by his colleagues and government officials on the occasion of completing nearly 60 years in the practice of medicine in Frederick.

Howard Moses, M.D., has opened his office in the Medical Arts Building, Baltimore, for the practice of Neurological Medicine and Pediatric Neurology, effective July 1. Dr. Moses holds Board certification in Neurology.

John R. Davis, M.D., Baltimore, has been reelected President of the Baltimore Area Council on Alcoholism, while John H. Hirschfeld, M.D., is first Vice President of the same group.

Umberto VillaSanta, M.D., Assistant Professo of OB-GYN, University of Maryland School of Medicine, presented a paper on Thromboembol Disease in Pregnancy, at the 13th Annual Clinical Meeting of the American College of OB-GYN, in April.

Frank K. Morris, M.D., has been named a Knight of St. Gregory by Pope Paul, through Cardinal Shehan.

TAX BRIEFS

Advice has been received from our legal couns that premiums paid by physicians for malpractic insurance are deductible as business expenses. Deduction is also allowable to physician who is employee of hospital, where he is personally liable for negligence.

Some confusion exists regarding the deduction medical society dues and assessments. These are <u>fully</u> deductible, as professional expenses, when computing net taxable income.

LEGISLATION

Senate Bill 170, the Psychiatrist/Patient Privileged Communication Bill, has been vetoe by the Governor and referred to the Legislativ Council for the drafting of an appropriate bill that the Governor can sign. Discussions are now under way with all parties concerned.

John Sargeant

Executive Secretary

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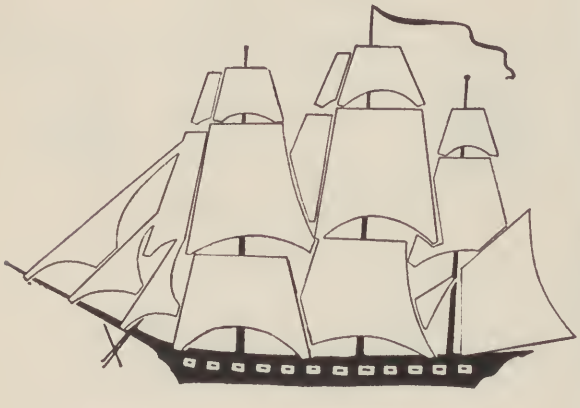
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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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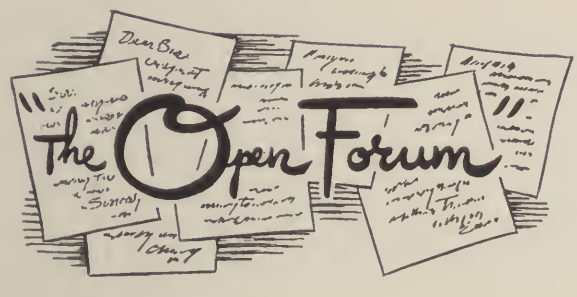
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To The Editor:

Since the MARYLAND STATE MEDICAL JOURNAL does not devote a section to correspondence, I am at a loss as to just how to address the following. However, I do feel that the subject is pertinent and of concern to the physicians of Maryland and hope, therefore, that you will be able to include it somehow.

I have been alarmed recently by two cases which I have seen and which seem to represent a dangerous and unbridled approach to the subject of the diagnosis of carcinoma. Specifically, this has to do with the management of patients in whom a Class III (doubtful, possibly malignant) cytological test for cancer is obtained from the cervix during pregnancy. Since patients in this category may be just starting their childbearing careers; since the Class III smear indicates only "doubtful, possibly malignant" disease, and since the diagnosis even when positive concerns a very early and relatively benign stage of the disease, it would seem most important to avoid any diagnostic approach which could cause abortion and/or leave a non-cancer bearing cervix irreparably damaged and the patient an obstetrical-gynecological cripple.

The first case concerns a 19-year-old gravida I, followed jointly by one of the local doctors and the County Maternal Health Clinic. A smear taken in early pregnancy was reported by the American Cancer Society Laboratory as Class III. A repeat smear was classified as Class II, Trichomonas present; a third smear was again Class III. Shortly thereafter, at approximately 37 weeks, she was presented by the local physician at a postgraduate clinical seminar in Baltimore. The gynecologist conducting the seminar advised immediate conization of the cervix. I saw her in consultation during the same week and found the vertex engaged, the cervical mucosa intact, and the cervical canal approximately 75% effaced. There was a marked trichomonas infestation. Smears taken by me were read by the local hospital pathologist as Class I. Obviously, any thought of cervical conization would have been ridiculous. My suggestion was to allow the patient to deliver below, treat her severe trichomonas vaginitis vigorously postpartum, and repeat the smears after her first postpartum menstrual period.

The second patient was a 28-year-old, three months secunda-gravida when she was first seen in December, 1963, by a local obstetrician. Smears were done and reported Class III. The pathologist suggested "D&C and conization," and the obstetrician did his best to comply. Two weeks later cold conization was performed—the pathologist's report "chronic cervicitis with atypical metaplasia." The patient bled profusely for four weeks postoperative and finally spontaneously aborted. Approximately 8-10 weeks thereafter "multiquad biopsies" were carried out—the pathologist's report again "cervicitis with atypical metaplasia." Subsequent smears done in August, 1964, and February, 1965, were diagnosed Class I. This patient has one of the most grossly distorted cervices I have ever seen, and there is reason to doubt its obstetrical competence. Since the LMP in her present pregnancy, she has had several episodes of bleeding and cramps but so far has not aborted.

The diagnostic attitude exemplified herein is consistent, I understand, with the policy of the faculty to which the two specialists concerned belong. However that might be, my opinion is that the advice and treatment in both cases leave much to be desired, particularly in that it is apparently the disease which is being treated and not the patient. It is inconceivable that a 19-year-old primigravida, three weeks from term, with only a Class III CTC smear could be considered a candidate for conization by any thinking gynecologist. The second case more than demonstrates how tragic the outcome of this injudicious approach can be. As regards the latter, perhaps one salves his conscience on the basis of the all-out treatment of CANCER. The point, however, is that there is a hell of a lot of difference between a Class III smear in pregnancy and CANCER, or even Stage 0 cancer of the cervix.

In summary, although cervical conization can with deliberation be applied successfully in pregnancy, the risk to the pregnancy and the additional risk, both immediate and future, to the mother



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must be justified. Since a Class III smear indicates only "doubtful or possibly malignant" disease and can, particularly in pregnancy, be an indication of only an inflammatory process, such all out treatment is certainly not justified. The treatment of cancer, whether it be "petit mal" or in a more advanced stage must be undertaken on an individual basis and does not lend itself to generalizations.

Stuart M. Christhilf, Jr., MD

To The Editor:

Thank you for allowing me to read a copy of the letter from Stuart Christhilf, which you are planning to publish in the June issue of the MARYLAND STATE MEDICAL JOURNAL.

In my opinion, Dr. Christhilf's letter conveys a message of importance to the practicing Maryland physician. It seems unlikely that any further comments are indicated.

Arthur L. Haskins, MD

To The Editor:

I appreciate the opportunity to comment on the letter written to you by Dr. Christhilf. I quite agree with the point that conization in pregnancy is not to be undertaken lightly. In fact, with the precision that cytology has attained with a carefully taken interpreted biopsy and with the use of the culposcope, the necessity for conization is diminishing even in the non-pregnant.

I would be remiss, however, were I not to call attention to some puzzling comments of Dr. Christhilf. The American Cancer Society does not have a laboratory which receives specimens for analysis from pregnant patients. I, therefore, do not know which laboratory Dr. Chrishilf had in mind. I know of no postgraduate clinical seminar in Baltimore sponsored by either medical school to which such a patient could have been presented. I am disturbed by the fact that a clinician would be persuaded to do a cone or any other procedure because it was suggested by the pathologist. This is a clinical decision to be decided by the clinician. Dr. Christhilf says the diagnostic procedure is consistent with the policy of the faculty to which the two specialists belong. I am sure that one can find individuals among gynecologists at large, whether they are faculty members, or not who might subscribe to doing conizations in pregnancy,

but I think I can speak for both the faculties at Johns Hopkins and the University of Maryland when I say that such an attitude would be the exception rather than the rule. The responsibility for looking after the patient rests with the person who is her personal physician.

Howard W. Jones, Jr., MD

To The Editor:

An assessment of $50 was enacted in the recent special session of the House of Delegates, called so hastily that Baltimore City Medical Society, whose 1,400 members constitute 50% of the active membership of the state, had had no meeting to discuss the resolution. The stated purpose of the assessment, so optimistically estimated to yield $140,000, was to educate the public concerning the role of American medicine. One of the speakers was frank enough to say that the money was to be used to change the public image of the physician.

The doctor-patient relationship of the American physician is excellent and needs no change. Whose image needs changing? It is the image of the AMA because of its insensitivity to the crushing burden the cost of modern medical care has placed on elderly people of minimum and moderate means. Its denial of the problem and political tactics have blocked for many years federal measures to ease this burden. In so doing, it has worn out the patience of the country and alienated Congress as well as the people. Now that it has forfeited its birthright in wasting its opportunity to lead and guide the sociomedical measures being passed by Congress, it hastily and belatedly comes forth with a contrived concoction called "Eldercare."

This is a program in which, hopefully, each state, at its own pleasure, will voluntarily assume a great portion of the financial burden of the elderly indigent and medically indigent, and, hopefully, all persons over 65 whose income exceeds a bare subsistence level will voluntarily buy insurance to cover the costs of hospital and medical and surgical care. In their overzealous propaganda



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for this curious creation, the AMA so overstepped the limits of truth that it was publicly rebuked by Congressman Herlong, cosponsor of the "Eldercare" bill. This, alone, reveals how far the AMA has strayed from the haven of prudent conservatism into the path of reactionary radicalism.

No deathbed conversion and no "educational program" are going to cleanse the tarnished image of official American medicine. To have the American citizen see the association of American physicians in the same light he regards his family doctor, it must reflect the practitioner's humanity and social responsibility. Revitalization must come from its grass roots. But great changes must be made before this can come to pass.

This can be done only through a more democratic representation. The American doctor must throw off his apathy and play an active part in medical society affairs. Only then can the structures of the state medical societies and of the AMA be changed so that the House of Delegates will truly represent the views of the great majority of American physicians. If these views are in doubt, a poll could be taken quickly and easily through the weekly *AMA Journal*. Thus, the AMA could reflect the American physician at all times.

The AMA image cannot be changed by propaganda and lobbying, even though millions, obtained through assessments and medical journal advertising, are spent. It can be accomplished only by drastic changes in AMA attitudes. The AMA must drop its obstructive tactics and redevote itself to professional excellence. When the AMA truly speaks with the voice of the American physician, its image will be good.

L. R. Schoolman, MD
Frederick, Md.

To The Editor:

This letter is written in order to convey to you my feelings about the recent so-called assessment.

The Medical and Chirurgical Faculty was founded as a scientific society and as such is entitled to expect all active members to pay their dues and any appropriate assessments. The present request however, cannot be regarded as an assessment; rather it is a "political levy." Furthermore, the threat to remove the right to legal aid from those physicians who do not contribute is blackmail, pure and simple. The Medical and Chirurgical Faculty, if anxious to preserve any semblance of dignity, would be well advised to avoid this sort of blatant extortion.

It seems obvious that the hierarchy of the Faculty sanctioned the printing of a large mass of propaganda and then were unable to pay the costs. This they did in a most highhanded manner without allowing the rank and file of the Faculty to register their disapproval. As a result of their misguided actions, I am asked to help finance a campaign for the adoption of Eldercare; a Bill that was begotten five years too late, spawned in desperation, with no chance of adoption and aside from this inadequate. Its family tree should read: "Eldercare" (stillborn) by "AMA" (a sire noted for his sterile mind) out of "Abject Reaction."

No, sir, I do not intend to pay this $50. I would advise the Faculty to think again before it becomes involved in any form of extortion.

I would close by saying that I am quite willing to contribute $50 to any charity named by the Medical Faculty in lieu of this political levy, but do not ask me to contribute to a futile cause which, moreover, goes against the dictates of my conscience. Education of the public is a worthy project, but do not confuse education with propaganda.

William Keith C. Morgan, MD

DIAGNOSIS: Doctor is worried, lest poor planning and needless taxes deprive his family of a large percentage of his estate.

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COUNCIL, APRIL 21

1. The minutes of the April 1 Executive Committee meeting were amended by adding under the $50 assessment item the following:

These funds will be kept separate from Faculty general funds and will be utilized only for the purposes designated by the House of Delegates in its resolution, with any investment income accruing to the benefit of the Educational Fund and not Faculty general funds.

2. Approval was given to deferring payment of 1965 dues by a Baltimore County physician until July, 1965, with all rights and privileges of membership through that date.

3. Reappointments to the Advisory Council on Medical Care, State Department of Health, were approved.

4. Names for submission to the Governor for appointment to the Board of Physical Therapy Examiners were approved.

5. Appointment by the President of an Ad Hoc Committee on Tuberculosis was approved, said committee to study the problem and make recommendations at the June Council meeting. The Council also approved in principle the formation of a Maryland Tuberculosis Commission.

6. Physicians defense was ratified for members requesting it.

7. Privileges of physicians defense were granted to a physician who, through a misunderstanding, made a late dues payment.

8. 1965 dues of a Prince George's County physician were refunded because of illness. 1966 dues of a Baltimore City physician were also remitted, at the request of the City Medical Society, because of illness.

9. An expression of appreciation and a rising vote of thanks were accorded the following retiring members of the Council: Carlton Brinsfield, MD, Henry P. Laughlin, MD, M. McKendree Boyer, MD, and Howard B. Mays, MD.

HOUSE OF DELEGATES, APRIL 21

1. A moment of silence was observed in memory of members who had died during the past year.

2. Emeritus membership was approved for the following members, as recommended by the Council: Emmett L. Jones, MD, Allegany County; Harry Linden, MD, and John C. Whitehorn, MD, Baltimore City; William H. F. Warthen, MD, Baltimore County; Thomas F. Vestal, MD, Carroll County; Harry H. Hamilton, MD, Kent County; Royal A. Bell, MD, and Henry F. Graff, MD, Washington County.

3. The following recommendation of the Professional Fee Fund Committee was adopted:

RESOLVED that the Council distribute a questionnaire requiring each member to return a statement in writing that he either is or is not disposing of his professional attainments or services to any hospital, corporation, or lay body, by whatever name called or however organized, under terms and conditions which permit the sale of services of that physician by such agency for a fee.

COUNCIL, APRIL 23

Russell S. Fisher, MD, was re-elected Council chairman, and Richard D. Bauer, MD, was re-elected vice chairman.

HOUSE OF DELEGATES, APRIL 23

1. Announcement was made that Wilber R. Ellis, MD, and Vernon H. Norwood, MD, had been re-elected to the Board of Medical Examiners, to serve until June, 1969.

2. The slate of officers presented by the Nominating Committee was accepted by unanimous consent.

3. Resolutions as presented by the Reference Committee were acted on as follows:

Resolution 1A/65, favoring "adoption of a modern code" enabling physicians and surgeons to incorporate, was not adopted.

Resolution 2A/65, requesting the Faculty to poll its members as to whether or not they wish to participate in the Social Security System, was not adopted.

Resolution 3A/65, requesting the AMA to return a grant from the tobacco industry, was not adopted.

4. A policy resolution presented by the Baltimore City Medical Society delegation was defeated. This resolution called for changing the February 20 action of the House to a voluntary contribution of $50 from active members to be used for public and professional education.

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References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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RATTLESNAKE



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Mapping Maryland's Snakebites

Maryland has the lowest annual snakebite rate in the South Atlantic states. About 42 people (18 inpatients and 24 outpatients) are bitten by snakes annually, an incidence of 1.35 bites per 100,000 people. The estimated case-fatality rate was less than 1%.

Of 33 inpatients reported in detail by Maryland hospitals during 1958 and 1959, 12 were bitten by copperheads, one by a foreign snake, and 20 by unidentified poisonous snakes. There was reason to believe that most of the unidentified snakes were copperheads.

Seasonal epidemics of snakebites occurred. 97% of the bites being inflicted from May through October. July was the peak month. Most of the bite accidents were reported from the central portion of the state.

Males had higher bite rates than females, and caucasians had higher rates than non-whites. Sixty-four per cent of the patients were younger than 20. All of the bites were on the extremities: 44% on the upper extremities and 56% on the lower extremities. Current snakebite treatment is discussed.

From the Department of Community Health and Medical Practice, School of Medicine, University of Missouri, Columbia.
This investigation was supported in part by Public Health Service Research Grant GM 11268-02 from the Division of General Medical Sciences, Public Health Service.

HENRY M. PARRISH, MD, DrPH

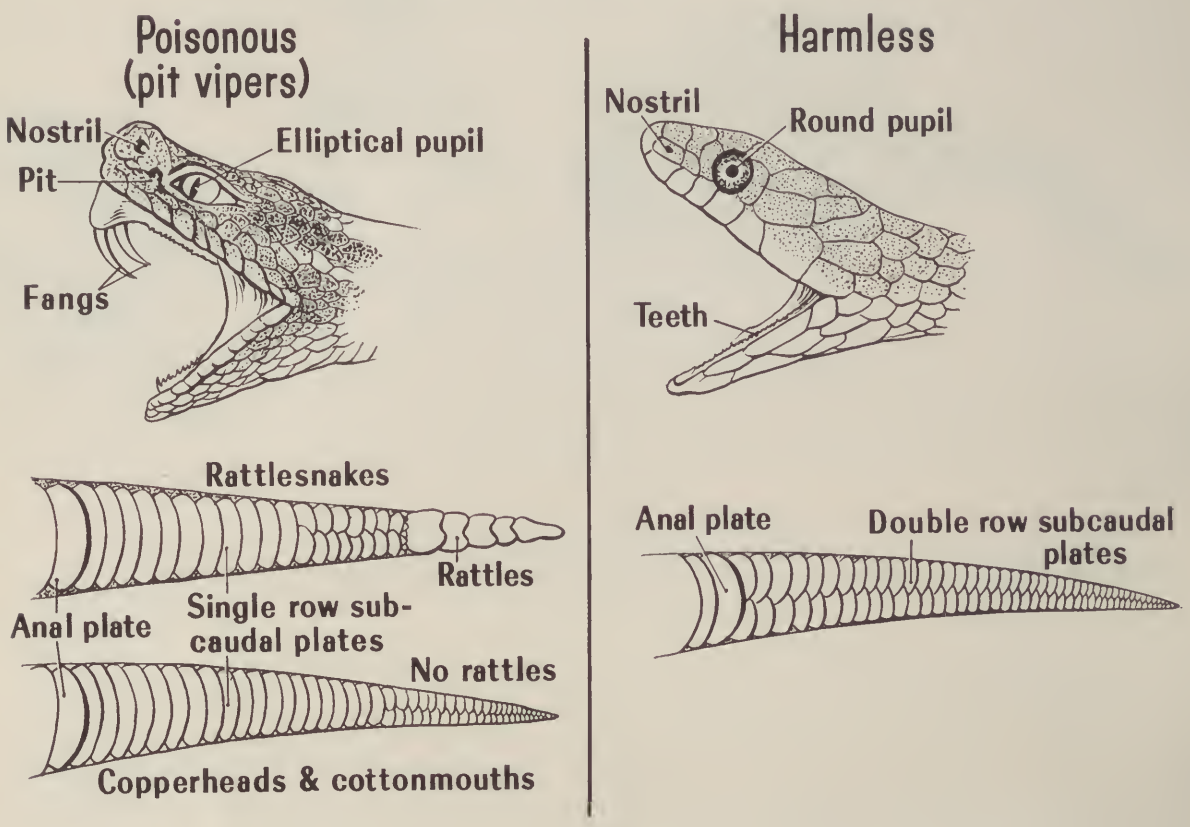


Fig. 2

SNAKE VENOM POISONING is a problem of considerable medical importance in the South Atlantic states. More than 2,000 people are treated for poisonous snakebites each year in this region. The highest annual snakebite rates per 100,000 population are found in North Carolina (18.79), Georgia (13.44), and West Virginia (11.29). Since Maryland borders West Virginia, it seemed worthwhile to map Maryland's poisonous snakebites. Two people died from poisonous snakebites in Maryland during the 10-year period 1950-1959.[1]

The purposes of this study are: 1) to define the epidemiology of poisonous snakebites in Maryland; 2) to relate some medical findings associated with these bites; and 3) to review briefly current concepts of snakebite treatment.

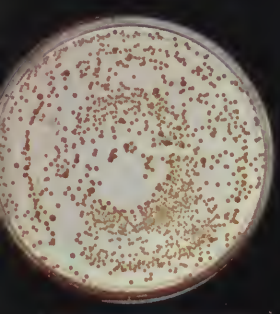
POISONOUS SNAKES

Two species of poisonous snakes are indigenous to Maryland:[2] the timber rattlesnake (*Crotalus horridus horridus*) and the northern copperhead (*Agkistrodon contortrix mokeson*). These are pictured in Fig. 1. Both of these snakes are pit vipers. They are so named because of a characteristic pit located between the eye and nostril on each side of the body. Pit vipers are identified also by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tail. Copperheads and harmless snakes do not have rattles. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Often people will chop off the head of a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by a single row of subcaudal plates on the belly just below the anal plate. Harmless snakes have a double row of subcaudal plates. Fig. 2 depicts the characteristic features of pit vipers and harmless snakes.

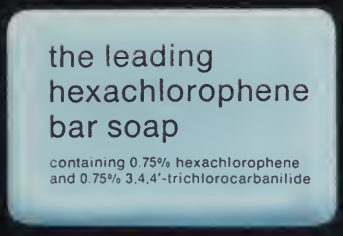
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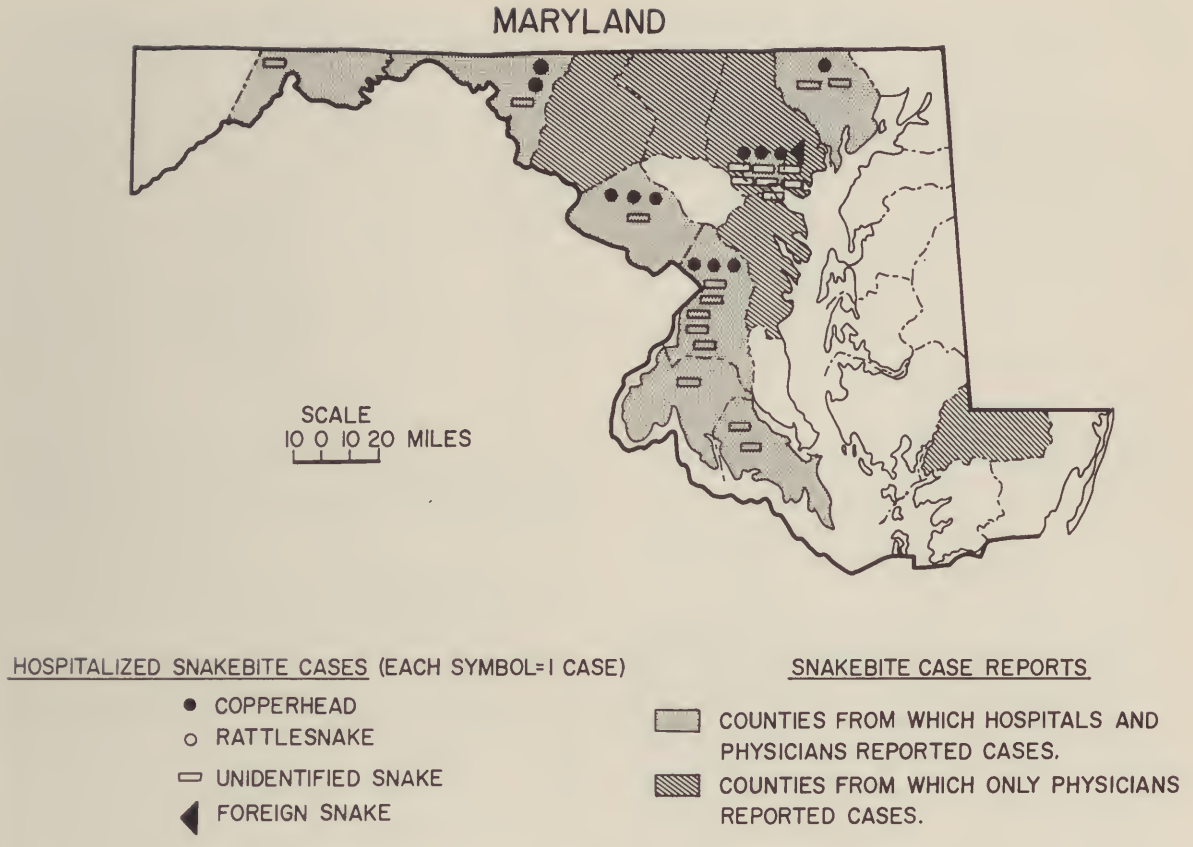


Fig. 3

METHODS OF STUDY

A questionnaire and letter explaining the purpose of this study were mailed to a selected group of Maryland hospitals listed in the *Hospitals* (Journal of the American Hospital Association) guide issue. The hospitals selected for this study were general hospitals, children's hospitals, and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force, and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis, and mental hospitals were omitted, as they would not be expected to treat snakebite victims. Forty-seven Maryland hospitals were asked to report all inpatients admitted for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and outpatient clinic visits. Since some snakebite victims are not admitted to the hospital as inpatients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an outpatient (office, home, emergency room) and an inpatient basis. Previous surveys,[3, 4] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. Therefore, a random sample comprising one-third of all the Maryland physicians in these categories of practice who were listed in the AMA Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the Maryland State Department of Health.

RESULTS

This report is based on questionnaires returned by 46 Maryland hospitals and is supplemented by questionnaires returned by 348 practicing physicians in the state. The Maryland State Department of Health reported one snakebite death during 1958 and none during 1959.

Incidence.—Maryland hospitals reported 33 inpatients treated for poisonous snakebites during 1958 and 1959. There were 17 cases in 1958 and 16 cases in 1959. All of the analyses in this paper,

excluding the estimate of incidence, are based on the 33 detailed case reports received from hospitals.

Physicians' reports, when adjusted to account for all Maryland physicians in the practice categories mentioned, indicated that approximately 18 inpatients and 24 outpatients were treated for snakebite accidents each year. The difference between the estimate of 18 inpatients treated by physicians and the average of 16 inpatients reported by hospitals can be explained by the following fact: there was evidence of under-reporting snakebite inpatients from two hospitals which participated in the study. Therefore, I estimate that approximately 42 (18 inpatients and 24 outpatients) people are treated annually for poisonous snakebites in Maryland. This provides an incidence of 1.35 bites per 100,000 population per year.

Geopathology.—The geographical distribution of snakebites reported in Maryland during 1958 and 1959 is shown in Fig. 3. The lightly shaded counties are those from which hospitals reported inpatients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases but from which no cases were reported by hospitals.

Of 33 people hospitalized for snakebite treatment for whom detailed records were available, 12 were bitten by copperheads, one by a foreign snake, and 20 by unidentified poisonous snakes. A careful analysis showed that the severity of venom poisoning resulting from bites by identified and unidentified poisonous snakes was similar. Most of the bites by unidentified poisonous snakes were inflicted on children. The geographical map of bites by unidentified poisonous snakes fits the ecological range for copperheads, suggesting that these probably were copperhead bites.

No timber rattlesnake bites were reported. The bite by a foreign snake involved a zookeeper in Baltimore, who was bitten by a captive Okinawa habu (*Trimeresurus okinavensis*). Fortunately, the habu is a pit viper, similar to our North American pit vipers, and Antivenin Crotalidae Polyvalent is effective in neutralizing its venom.

Snakebites were reported from all sections of the state but most frequently from the central portion, infrequently from the eastern and western areas. Conant's [2] snake maps show that copperheads have a statewide distribution and that timber rattlesnakes are confined to the western third of the state. The present study indicates that the copperhead is responsible for most of Maryland's poisonous snakebites.

TABLE 1

SEASONAL DISTRIBUTION OF POISONOUS SNAKEBITES IN MARYLAND, 1958 AND 1959

Month	No. Bites	Month	No. Bites
January	0	July	8
February	0	August	5
March	0	September	6
April	0	October	2
May	7	November	1
June	4	December	0

Temporal Relationships.—The monthly distribution of snakebite accidents is shown in Table 1. In general, snakes are usually inactive or hibernating during the colder months. Most snakebites occurred from May through October, when 97% of the bites were inflicted. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and that people have greater exposure due to outdoor occupations and recreation. Similar seasonal epidemics of venomous snakebites have been observed in New England, and Florida.[3, 4]

The time of day when most snakebite accidents happened was the three-hour period from 12 noon to 2:59 PM, when 11 people were bitten. Eighty per cent of the bites occurred from 12 noon to 8:59 PM. The time was not stated for one case. The number of bites in each three hour period was: 6-8:59 AM, two bites; 9-11:59 AM, one bite; 12 noon-2:59 PM, 11 bites; 3-5:59 PM, seven bites; 6-8:59 PM, eight bites; and 9-11 PM, three bites. There were no bites from 12 midnight to 5:59 AM.

Bite Victims.—There were 18 white males, 12 white females, two non-white males, and one non-white female admitted to Maryland hospitals for snakebite treatment during 1958 and 1959. The three non-whites were Negroes. Using the 1960 census of the population of Maryland, the bite rates per 100,000 population were: 1.41 for white males, 0.77 for non-white males, 0.92 for white females, and 0.37 for non-white females.

The age distribution of Maryland's bite victims

TABLE 2
AGE DISTRIBUTION OF HOSPITALIZED SNAKEBITE VICTIMS IN MARYLAND, 1958 AND 1959

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0–9	693,131	11	1.58
10–19	520,252	10	1.92
20–29	384,894	3	0.78
30–39	467,063	1	0.21
40–49	405,604	2	0.49
50–59	290,599	4	1.38
60–69	195,859	1	0.51
70 or more	138,287	1	0.72

*Based on the 1960 Census of the Population of Maryland.

**These rates are only on hospitalized patients for whom information was available.

is shown in Table 2. Sixty-four per cent of all snakebites were inflicted on children and young adults less than 20 years of age. Age-specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rate per 100,000 population was found for those 10 to 19 years of age (1.92). The lowest bite rate was found among people 30 to 39 years of age.

An analysis of the occupations of the adult patients showed that four were farmers or farm laborers, four were craftsmen, three were laborers other than farm and mine, and one each of the following: housewife, clerical worker, operative, professional, and armed forces member.

Activity and Place.—Six bites occurred while children were playing outside, three in their own yard and three elsewhere. Four people were bitten while walking or working in their own yard; three while engaging in recreation other than hunting and fishing; three while handling a poisonous snake; two while hunting or fishing; and one each while working on a farm, picking up lumber, and working or playing in a barn or henhouse. The activity was not coded for the remaining patients.

The place where the bite accident happened is closely related to the activity when bitten. Seven snakebites occurred in the patient's own yard; five in the woods; four in or near a lake, river, or other body of water; four in or under a building; two in a field near the house; one on a farm not near the house; and one in a rock quarry. Of the four people bitten in a building, one was bitten while handling a snake in a zoo, one while handling a "pet" copperhead at home, one while handling a copperhead at an Armed Forces Day exhibit, and one on the porch of his home. The place where the bite happened was not coded for the other patients.

Site and Severity.—The anatomical sites where the bites were inflicted are shown in Table 3.

TABLE 3
ANATOMICAL SITES OF BITES INFLICTED BY POISONOUS SNAKES IN MARYLAND, 1958 AND 1959

Anatomical Site of Bite	Side of Body		Total No. of Bites
	Right	Left	
Head, face & neck	0	0	0
Trunk, front	0	0	0
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	1	1	2
Hand	1	1	2
Fingers	3	7	10
Upper leg	1	0	1
Lower leg & ankle	4	7	11
Foot	4	1	5
Toes	1	0	1
Not stated	—	—	1

All occurred on the extremities, 44% on the upper extremities and 56% on the lower extremities.

A modification of the clinical classification of pit viper venenation by Wood, Hoback, and Green [5] was used to determine the severity of bites. Bites were classified as follows:

Grade 0 —*No venenation.* Fang or tooth marks, minimal pain, less than one inch of surrounding edema and erythema. No systemic involvement.

Grade I —*Minimal venenation.* Fang or tooth marks, severe pain, one to five inches of surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually present.

Grade II —*Moderate venenation.* Fang or tooth

marks, severe pain, six to 12 inches of surrounding edema and erythema in first 12 hours after bite. Systemic involvement may be present —nausea, vomiting, giddiness, shock, or neurotoxic symptoms.

Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite. Systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 26 hospitalized cases: nine were Grade 0; 10 were Grade I; four were Grade II; and three were Grade III. For the remaining seven hospitalized cases the severity of venenation was not stated.

There was one death among the 33 hospitalized cases reported in this series. Considering that about 57% of all poisonous snakebites in Maryland are treated on an outpatient basis, the true case-fatality rate probably is less than 1%. This is confirmed by the fact that there were only two snakebite deaths in the state during the period 1950-1959.[1] The death in 1958 involved a three-year-old Negro girl who was bitten twice on the left leg by an unidentified poisonous snake while playing in a corn crib. She died two days after the bite. It seems likely that she was bitten twice by a large copperhead because this is the only native snake found in south central Maryland. There were no deaths in the United States definitely attributed to copperheads from 1950-1959. Another fatal snakebite happened in Maryland in 1955. A 25-year-old woman died from respiratory paralysis two days after being bitten on the right forearm by a cobra (*Naja sp.*). She was handling this deadly snake during a nightclub performance. Contrary to popular belief, few patients in the United States die within the first few hours after a poisonous snakebite. About 70% die from six to 48 hours after venenation takes place.[6]

TREATMENT

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin, and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation,* and it should be released every 10-15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically or until antivenin can be administered to neutralize the venom.

Incision and suction is effective in removing venom from experimental animals up to two hours after the venom is injected. The sooner it is used the more venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first aid kits effective for removing pit viper venom. Incisions, one quarter inch long and one eighth to one quarter inch deep, are made into the subcutaneous tissues over the fang punctures. Three to five additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom; however, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The three A's (antivenin, antibiotics, and tetanus antitoxin or toxoid) are recommended in addition to incision and suction in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given. For Grade I venenations, antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000 cc of normal saline may be given intravenously.[7] Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.[8] Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various grades of

venenation: Grade 0 (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10 cc (one ampoule) of antivenin; Grade II (moderate venenation) requires 30-40 cc of antivenin; and Grade III (severe venenation) requires 50 cc or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin or toxoid should be given prophylactically. Gram negative organisms predominate; hence a broad spectrum antibiotic is indicated. Penicillin alone is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution, and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride.[8] In our opinion, cold therapy should not be used in treating pit viper bites.

University of Missouri Medical School
Columbia, Mo.

REFERENCES

1. Parrish, H. M.: Analysis of 460 Fatalities From Venomous Animals in the United States, *Amer J Med Sci* 245:129-141 (Feb) 1963.
2. Conant, R.: *A Field Guide to Reptiles and Amphibians of Eastern North America,* Boston: Houghton Mifflin Co., 1958.
3. Parrish, H. M.: On the Incidence of Poisonous Snakebites in Florida: Analysis of 241 Cases Occurring During 1954 and 1955, *Amer J Trop Med* 6:761-765 (July) 1957.
4. Parrish, H. M., Badgley, R. F., and Carr, C. A.: Poisonous Snake Bites in New England, *New Eng J Med* 263:788-793 (Oct. 20) 1960.
5. Wood, J. T., Hoback, W. W., and Green, T. W.: Treatment of Snake Venom Poisoning with ACTH and Cortisone, *Virginia Med Monthly* 82:130-135 (March) 1955.
6. Parrish, H. M.: Mortality From Snakebites, United States, 1950-1954, *Public Health Rep* 72:1027-1030 (Nov) 1957.
7. Parrish, H. M.: Intravenous Antivenin in Clinical Snake Venom Poisoning, *Missouri Med* 60:240-244 (March) 1963.
8. McCollough, N. C., and Gennaro, J. F., Jr.: Evaluation of Venomous Snake Bite in the Southern United States From Parallel Clinical and Laboratory Invesitgations: Development of Treatment, *J Florida Med Asso* 49:959-967 (June) 1963.



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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

EFFORTS TOWARD SOCIALIZED MEDICAL CARE

Third-party intervention between the doctor and his patient already exists in many areas. The problem in this country is not so much whether the government will take over the practice of medicine as it is how to maintain the professionalism and professional integrity of medicine in the face of the many forces tending to reduce the physician to the status of an employee.

PAUL BERMAN
Member, Baltimore City Bar

The medical profession, likewise is being threatened with radical legislation, and, in fact, is already the victim of some reforms that are not in the best interest of that profession or the public generally.

While this country is still far from complete socialized medicine such as exists in England, where the government provides complete medical services for every citizen by employing physicians and furnishing hospital accommodations to all persons who need them, there is an undercurrent toward the adoption of that system. Under the English system, which is truly socialized medicine, physicians and those furnishing health services are essentially employees of the state.

There are, however, a number of developments on the American scene as a result of which "third party intervention" between the doctor and his patient has been increasing a measure of lay control over how the doctor treats his patient and how much fee he may charge. There are several forms in which this third party intervention has been developing.

First, the so-called voluntary health insurance programs of the Blue Cross and Blue Shield exert a substantial measure of control over physicians. Blue Cross covers certain procedures and does not cover others. In general, Blue Cross is hospital-oriented. The existence of the Blue Cross plan exerts a powerful financial pressure on a physician to treat a situation by means of hospitalization or in accordance with a procedure which the plan will pay for, rather than perhaps a medically superior procedure not covered by the plan. Blue Shield requires a physician to accept the Blue Shield fee schedule as full compensation when the patient does not make more than a specified income. In such a case, the physician has obviously lost his right to set his own fees. In addition, Blue Shield has a Medical Review Board which is supposed to weed out unjustified claims, including claims for unnecessary, incompetent, or

Part 3 of a talk entitled "Some Observations by a Trial Lawyer on Cooperation Between the Legal and Medical Professions," given May 23, 1963, at a joint meeting of the Bar Associations and Medical Societies of Allegany and Garrett Counties.

medically unjustified treatment. To the extent that such review is effective, the physician who treats a patient loses a measure of control over his choice of methods of treatment and is subjected to economic pressure to conform his treatment to a particular norm or standard.

A variant form of voluntary insurance which affects physicians even more drastically is the type of group health plans such as the Washington, D. C. Group Health Plan or the New York Health Insurance Plan (HIP). These plans provide complete health services for the policyholder's premium. A physician who joins the plan agrees, in treating any plan member, to accept the fee schedule provided by the plan, and the physician's relationship directly with the patient is affected by the existence of the plan and its regulations in the background. These plans are more drastic because they do not provide for supplemental bills by the physician above and beyond what the plan provides.

The second important impetus to socialization of medicine by way of the increase of third party intervention between the doctor and patient has been the change in the institutional pattern of medical practice itself. The greatest defense against the socialization of medicine in the past has been the independent medical practitioner. In recent years less and less of the practice of medicine has been done by such practitioners. The increase of the fulltime system in the large hospitals has resulted in the creation of "employee doctors," who do research and may even be heads of departments. The need for hospital privileges and the specialist-orientation of the hospital accrediting standards limit the opportunities of all but specialists to have hospital privileges, and all physicians who have such privileges are under the control of hospital regulations which are ultimately subject to the approval of a lay board. Numerous specialties which used to be practiced privately, such as radiology, pathology, and anesthesiology, are now claimed by hospitals as ancillary services. Throughout the country in these specialties there has been a tendency for the physician to be a fulltime employee of the hospital. When this occurs, a hospital radiologist, for example, may not be able to secure the type of x-ray equipment and film or the type of technician he desires. He may not be able to control his case load or set the fees for his services or do a number of other things that an independent practitioner could do if he were rendering the services. To the extent that these medical decisions are subject to hospital policies and budgets, there is a strong limitation upon the physician's control over the relationship with his patient.

A particularly important change in the institutional practice of medicine is the so-called closed panel. Under this plan, a labor union, for example, will engage a number of physicians as fulltime employees, or an industry may employ a panel of physicians to treat its employees, such treatment being in the nature of a fringe benefit. In some labor unions, the closed panel operates in conjunction with a private hospital for union members. In such a case, the physicians are employed by a union or corporation to furnish services to a large group of individuals. The party who pays, namely, the union, has the right within broad limits, to call the tune; and the doctor's control over the nature and quality of his practice is limited by the fact that he is employed by a lay party other than the patient.

The third important source from which features of socialization have been injected into the practice of medicine is legislation. For example, the Kerr-Mills Act, 42 USCA 301, etc. passed in 1960, set up a program whereby the federal government would pay the states a substantial part of the cost of treatment under an approved plan for the care of the medically indigent aged. They are defined as "aged individuals who are not recipients of old age assistance but whose income and resources are insufficient to meet the cost of necessary medical service." The state plan must be supervised by a state agency, requires the establishment of standards for public and private institutions, and standards for the extent of assistance. Typical state statutes, such as the Maryland Statute for the Medical Care of the Indigent, Code, Article 43, Sections 42-43, provide that the State Board of Health or a similiar agency may conduct hospitals and may contract with physicians to provide for the medical and surgical treatment of eligible persons. The Maryland State plan is administered by the Board of Health, with an advisory counsel consisting of representatives of physicians, the State Board of Health, medical schools, hospitals, the Welfare Department, dentists, nurses, and pharmacists. Obviously, here the control over the physician is asserted

through the contract between the State Board of Health and the physician which supercedes the relationship between the patient and physician.

The most extensive legislative involvement of the government in medical practice so far proposed has been the President's program for medical care to elderly citizens, which was defeated by a very close vote in the Senate last year. This was a proposal to provide for substantially all of the medical needs of the people of this country over 65 years of age covered by the social security system. It would be financed by an increase in the social security tax. The physicians, for the time being, have successfully resisted this plan on the basis of two principal arguments: 1) It would increase social security tax on everyone and would provide medical assistance even for people who could well afford to pay for it. In this condition, it was urged that the Kerr-Mills Act, which is limited to assisting those who need it, should be given a further trial before the President's more drastic proposal was enacted. 2) The physicians saw a threat of too much control of medicine by the government. The definition of the type of medical assistance to be covered would give the government extensive power by economic pressure to dictate, for example, the type of medical procedure, or the type of prescription, or the place of treatment, by exerting economic pressure in favor of the treatment defined in the statute, and against all other alternative forms for which there would be no government payment.

A great many talk of socialized medicine and miss the point. The problem in this country is not so much whether the government will take over all the medical practice along the English model. I believe we are still quite far from this here. The problem is how to maintain the professionalism and professional integrity of medicine in the face of the tremendous forces inside medicine and out—of which the state is only one, tending to reduce the physician to the status of an employee, subject, in the final analysis, to lay control and no longer the master of his relationship to his own patients.

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BALTIMORE CITY

A capacity crowd attended the semiannual business meeting. I can't recall any previous meeting marked with such spirited discussions. When the dust settled, we were all the better for having shed light on the matter of educating the public and physicians about matters of community health care.

Philip Wagley, MD, submitted a resolution that we inform our delegates to the Medical and Chirurgical Faculty of our opposition to the recently passed $50 "war tax." An overwhelming majority supported the resolution in a standing vote. We were assured that only 15% of the $50 assessment would go specifically for supporting Eldercare against the King-Anderson bill, the remainder going to support a long range program of educating physicians and the general public about community health projects. However, many believed that the urgency of the recent faculty meeting attended by Dr. Donovan Ward could scarcely have been prompted by a need for a long term educational campaign.

Somehow the salvage of the "physicians' image" was mentioned as representing a portion of the propaganda effort. **Helen Taussig, MD,** who enjoys the singular distinction of applause before she speaks, commented, "I don't think that any of us should spend money on our image. If we do right, our image will take care of itself." She thought that it was a dangerous thing for a scientific society to become a political society.

In another motion, **George Vash, MD,** proposed that our delegates to the Medical and Chirurgical Faculty meeting urge the AMA to return the $10,000,000 grant given to the AMA by the tobacco industry. Noting that numerous independent objective reports had established the health dangers of cigarette smoking, Dr. Vash scolded the AMA for not taking a stand against cigarette smoking. Dr. Vash's resolution also received warm endorsement from his colleagues.

It was a thoroughly treasonous evening.

The Society has already received numerous complaints about the management of the meeting. The tenor of the complaints was that the president gave the floor to members who attended meetings infrequently. Others suspected that many members attended to swing some kind of political power play. I suppose the inference one could derive from these complaints is that a member should be forced to attend all meetings even if the matters, scientific or business, don't interest him in the least. **Dr. Morrison** has gone to great pains to be fair and impartial in presiding. He was so courteous as to read a statement from a member not in attendance and to give the floor to a physician from another county.

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MONTGOMERY COUNTY

Read N. Calvert, MD, fellow of the International College of Surgeons, attended the Caribbean convention cruise for 13 days. The ship visited Caracas, Venezuela, Netherlands West Indies, including the islands of Curacao and Aruba. They spent three days in Kingston, Jamaica. There were three scientific sessions held at the University of West Indies. Nine scientific sessions were held during the cruise. Dr. Calvert presented a color film on the Manchester Operation.

G. Lennard Gold, MD, presented a paper at the 50th annual meeting of the American College of Physicians, Chicago, on March 24. His topics was "Current Management of Malignant Lymphomas." Co-authors were **B. I. Shnider, MD,** and **J. J. Lynch, MD.**

Gilbert Barkin, MD, attended the American Academy of Pediatrics, Allergy Post-Graduate Course, in Houston, Texas, February 25-27. He presented three papers and was the first lecturer for the Texas Allergy Research Foundation.

At a recent meeting of the American Academy of Allergy held at Miami Beach, **Solomon E. Barr, MD,** was advanced to Fellowship.

Edward E. Ferguson, MD, chief of urology, Suburban Hospital, was elected president-elect of the Mid-Atlantic Section of the American Urological Association.

Marvin I. Mones, MD, received a letter of recognition from F. J. L. Blasingame, MD, executive vice president of the American Medical Association, for his participation in defending medical freedom during the recent 88th Congress.

J. Frederick Barr, MD, has recently been elected medical advisor to the National Hemorrhaphilia Foundation.

John Loy



WICOMICO COUNTY

MEETING WITH JEHOVAH'S WITNESSES

Representatives of Jehovah's Witnesses and the medical profession met in Salisbury recently in a mutual effort to resolve difficulties arising in medical treatment of members of that faith. It was the first time in this country that such a joint meeting has been held.

In recent years, increasing numbers of cases involving the question of blood transfusion for Jehovah's Witnesses, whose faith prohibits this treatment, have been brought to public attention. Lack of communication has resulted in misinterpretations on the part of some physicians and has at times created difficulty for Jehovah's Witnesses in seeking medical care.

Local members of the faith requested such a meeting, and the door was thus opened to further conferences in the hope that eventually a solution will be found to the problem. Further meetings are planned between the two groups in Wicomico County.

Because of the national scope of the topic, the **Rev. Dr. Paul B. McCleave,** director of medicine and religion for the AMA, and his assistant, **Arne Larson,** both of Chicago, were present for the meeting, as was **Fred Rusk** of the international Jehovah's Witnesses headquarters in Brooklyn, NY. After the meeting, both Mr. Rusk and Dr. McCleave expressed a desire to explore the subject at the national level.

Representing Jehovah's Witnesses of the Wicomico area were **Jack Ward, David Pedwell, Gordon Mills, James Seltzer, John Martin,** and **Lester Bonnett.** The Wicomico County Medical Society was represented by **Andrew C. Mitchell, MD,** president, **Robert T. Baker, MD,** Salisbury obstetrician and gynecologist, and **Thomas C. Hill MD,** chief of internal medicine at the Peninsula General Hospital. The meeting was held in the hospital's board room in the new school of nursing building.

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Andrew C. Mitchell, MD, president of the Wicomico County Medical Society, Inc., is "pinned" with a red carnation in observance of Doctor's Day, by Mrs. Virginia Layfield, assistant administrator of the Peninsula General Hospital. Assisting is Mrs. Margaret Yow (left) president of the Wicomico County Medical Society Woman's Auxiliary, which placed a large bowl of carnations in the hospital lobby.

DOCTOR'S DAY

On March 30 a red carnation was presented to each doctor by the Peninsula General Hospital in honor of Doctor's Day. The following letter was placed on the tray of each patient that day:

MEMORANDUM TO PATIENTS:

Today is Doctor's Day, a day observed annually to honor members of the Medical profession with some act of kindness, gift or recognition.

Peninsula General Hospital welcomes this opportunity to pay tribute to the members of the Medical Staff. Their unselfish gifts of time, knowledge and skill provide care for those patients who cannot afford to pay for services received. Few people realize the large financial gifts and many hours which the doctors donate to planning for improved medical services by the Hospital for all people in this area.

The red carnation is the symbol of Doctor's Day, chosen because it denotes honorary distinction. Its spicy fragrance was used in seasoning dishes "to preserve the body of men in mind and spirit." The color red signifies charity, sacrifice and courage.

The red carnation, as defined by this symbolism, represents the characteristics of our doctors. The Hospital, in order to show our appreciation and commendation, will present each doctor with a red carnation to wear in his lapel today. As you observe the doctors wearing this flower, you will know that we say in this way, a heartfelt, "Thank you!"

/s/ F. C. Thompson,
Administrator

TETANUS TOXOID BOOSTERS GIVEN

Nearly 1,000 booster shots of tetanus toxoid were given by the Wicomico County Medical Society, Inc., at the Better Living Exposition in Salisbury on April 9, 10, and 11.

Approximately 800 persons received the vaccine in late February at the Autorama, and all were invited to obtain a booster in April. For both rounds, no charge was made for the vaccine. Voluntary contributions of almost $500 were turned over to the Peninsula General Hospital Building Fund. Vaccine was purchased by the medical society; student nurses from the Peninsula General Hospital School of Nursing administered the shots, with a member of the Society present. The Woman's Auxiliary of the medical society handled registrations, and space was provided by the Optimists Club, sponsors of the Better Living Exposition.

Members participating in the April program were **James L. Erwin, MD, Robert T. Adkins, MD, John M. Bloxom III, MD, John T. Bulkeley, MD, Earl L. Royer, MD, Walter DeVault, MD, Ernest A. Purnell, MD, James P. Gallaher, MD, William B. Long, MD, Elias Adamopoulos, MD,** and **A. C. Kolls, MD.**

MEDICO-RELIGIOUS PROBLEMS OF MENTAL RETARDATION

Every day 340 retarded children are born in this country, according to the **Rev. Dr. Paul B. McCleave,** director of the Department of Medicine and Religion of the AMA. This amounts to 30 out of every 1,000 births, said Dr. McCleave in a speech before members of the Wicomico County Medical Society and their guests from the clergy of the Salisbury area, on April 12.

Parents of these children face countless problems from the moment retardation is discovered. Both the physicians and the clergymen must be prepared to offer counsel, Dr. McCleave said. Some of these problems include a sense of guilt felt by many of these parents as a result of their cultural, social, and religious background; the child's position in the family group (whether older or younger than the other children), and the decision whether the particular child should be institutionalized or cared for at home. These and other problems were touched upon, and Dr. McCleave pointed out that the present ability of the medical profession to preserve and sustain life is a major factor. Many of these children in past years did not survive, but their numbers are now creating a major social problem.

"I am not here to answer these questions, but rather to encourage thought and discussion among you," said Dr. McCleave, as he acknowledged that there are no guidelines for answering such questions. Each family, each physician, each clergyman, must arrive at an individual solution to each such case.

During the discussion period after Dr. McCleave's presentation, **Charles Bagley III, MD,** local psychiatrist, discussed some of the aspects of social segregation faced by these retarded children and their families. Presiding at the meeting was **Andrew C. Mitchell, MD,** president of the Wicomico County Medical Society. Approximately 60 members of the two professions attended the meeting and social hour



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which followed in the auditorium of the new Peninsula General Hospital School of Nursing building.

SPEAKERS

Ernest A. Purnell, MD, was the featured speaker for a meeting of the Social Concerns Committee of Wesley Temple Methodist Church in Salisbury. He discussed various plans for health care for the aged before Congress, including the so-called Medicare and Eldercare programs. Dr. Purnell is the assistant chief of the Department of General Practice at the Peninsula General Hospital.

Other speaking engagements in April included **Raymond M. Yow, MD,** addressing the Fruitland Lions Club, and **Mrs. Kit Hargreaves,** executive secretary for the society, speaking before the Hebron Lions Club, both on the subject of Eldercare; and an appearance by **Rufus S. Gardner, MD,** for the Mar-Zion Home Demonstration Club, his topic being food fads.

SPEECH CLINIC

Twenty-one persons attended the speech clinic presented on April 14 and 15 in Salisbury by Smith, Kline & French, under the auspices of the Wicomico County Medical Society, Inc.

Represented were medical societies throughout the Eastern Shore of Maryland as well as the Wicomico County society, the administrative staff of the Peninsula General Hospital, the Woman's Auxiliary of the medical society, and the Eastern Shore Dental Society.

All attending the clinic were most enthusiastic about its effectiveness, and we hope that future ones can be provided in the area.

Physicians attending included: **Ollie H. Thompson, MD, William B. Smith, MD, Earl M. Beardsley, MD, Andrew C. Mitchell, MD, E. Peyton Ritchings, MD, Stedman W. Smith, MD, Raymond M. Yow, MD, Gladys Allen, MD, Marcus Stephanides, MD,** and **I. Rivers Hanson, MD,** all of Salisbury; **Dale R. Kollman, MD,** of Easton, and **Harry P. Ross, MD,** of Chestertown.

⚙ *Mrs. Kit Hargreaves*

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Serum Enzymes
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ENZYMATIC ACTIVITY OF SERUM has received intensive investigation in the past few years, resulting in the publication of assay methods for about 50 enzymes. Although such methods have proven useful in investigative work, their adaptation to the clinical laboratory and their interpretation in clinical medicine have been received with mixed feelings by clinical pathologists and other physicians.

Some say that many diagnoses cannot be made without multiple serum enzyme determinations, whereas others see no use for such determinations. The truth lies somewhere between the extremes of view. Such radical views arise usually because of inadequate understanding of the tissue sources of circulating enzymes, the rate and extent of rise of enzyme activity, and clearance from the serum. Many physicians correlate that in one condition a certain enzyme goes up and another enzyme remains normal, whereas in another disease the opposite is true. This is certainly a naive view of a rather complex situation.

How does one go about defining the diagnostic possibilities of a serum enzyme or enzymes in clinical medicine? Articles on the use of an enzyme in clinical diagnosis may offer a biased view for several reasons. When an investigator has a new enzyme assay, it is only natural to look for clinical applications. When an application is found, it is also natural to "set the stage" by careful selection of patients so that the determination is "very applicable." Thus, selected series, ie, the best results, are published. I do not mean to imply that this is dishonest. The readers of the article may either comply or not comply with the suggestions for case selection when they further investigate the use of the enzyme in clinical diagnosis. Some, therefore, find that by careful selection of cases the determination is useful; others, by purposeful non-selection of cases, find that the usefulness is limited in the presence of complications or other diseases. Reading the second wave of articles can therefore bias one's outlook considerably. Each physician must discover the usefulness or uselessness of each serum enzyme in each clinical situation by critical review of the literature plus careful personal comparison of results not only in the pure illness but also in the face of all of its complications. Adequate experience to properly evaluate a new enzyme consequently takes at least one or two years of careful observation.

Before ordering serum enzyme determinations or attempting to interpret the results, one basic fact must be faced: the commonly performed serum enzymes are *not* tissue or organ specific. For example, renal infarction, myocardial infarction, passive congestion of the liver, portal cirrhosis, a small amount of crushed skeletal muscle, or hemolytic anemia may all produce a similar rise in SGOT. Does this mean that the enzyme determination is not useful? The answer depends entirely on the clinical setting in which the physician orders the test. If he orders enzyme studies indiscriminately in any clinical situation, the laboratory results will be useless in many instances. If, however, enzyme determinations are ordered only when the proper clinical setting is present, eg, a patient with chest pain without heart failure or other complications, a raised SGOT level may be strong and reliable evidence of the presence of otherwise occult myocardial infarction.

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tions has been used in an attempt to separate that SGOT elevation due to myocardial infarction from that seen with passive congestion of the liver due to clinically undetected minimal heart failure. In the proper clinical setting, a rise in SGOT with normal SGPT indicates myocardial infarction, whereas if both are raised, the rise in SGOT cannot be relied upon as an indication of myocardial infarction.

It should be quite obvious that the patient suffering massive myocardial infarction with cardiac arrest, shock, and anoxia is *not* the proper "clinical setting" for any enzyme determination since all enzyme levels will be greatly and nonselectively increased.

The absolute levels, as well as the relationship of SGOT and SGPT, have proven useful in the differential diagnosis of liver diseases. In homologous serum hepatitis, infectious hepatitis, and hepatitis as a complication of infectious mononucleosis, both enzymes are usually in the thousands and the SGPT level is almost always much higher than the SGOT level. By contrast, in posthepatic biliary tract obstruction without cholangitis, the SGOT and SGPT levels are usually commensurate and less than 400 Karmen units. The development of ascending cholangitis may rapidly change the enzyme picture from posthepatitis obstruction to hepatitis.

Even the "old guard" enzymes are misused. Acid phosphatase is one of the most misused in this group. How many physicians realize that not all cases of metastatic carcinoma of the prostate have a rise in acid phosphatase? In some series the incidence has been as low as 25% and in others as high as 90%. Prostatic acid phosphatase is extremely unstable, and several hours at room temperature will usually inactivate the enzyme. Also, hemolysis or inclusion of some red cells in the serum sample will raise the acid phosphatase level due to the presence of RBC acid phosphatase, giving false positive indication of the presence of prostatic carcinoma. Amazingly, some commercial laboratories will perform this test by mail. Furthermore, in some methods the substrate used is more efficient in detecting RBC acid phosphatase than prostatic acid phosphatase.

Using these methods, splenomegaly on any basis may result in a raised serum acid phosphatase. Vigorous rectal examination of an enlarged prostate usually increases the serum acid phosphatase for several days. Once again, the clinical setting is critical in determining the usefulness and validity of an enzyme determination.

In summary, the commonly performed serum enzymes are not tissue or organ specific. The proper clinical setting must be present or created for these determinations to be useful. Several commonly available enzymes have been used for illustration, but similar principles apply to all the serum enzymes.

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The Heart Page

George C. Roveti, MD—*Editor*

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Cardiovascular Training in the Community Hospital

GEORGE C. ROVETI, MD

WITH THE GROWING BODY of knowledge in all medical subspecialties, the planning of a well rounded medical residency training program has become increasingly challenging. The education of a well oriented internist, in a broad sense, with adequate exposure to all aspects of a complex discipline, is still the main purpose. While early emphasis of a narrow field may have restrictive influence and result in a distorted viewpoint, considerable stimulation can be achieved by a well organized, integrated, and, above all, continued teaching program in a given subspecialty.

Continuity, direct patient responsibility, and individual guidance, basic ingredients in the education of a physician, remain the keywords in spite of the teaching machines and computers. In our experience, the continuity and repetitive exposure to cardiovascular problems can be effectively achieved by the establishment of a weekly teaching session, preferably in the form of a luncheon meeting combined with walking rounds.

The program of these exercises includes the following:

1) Case presentations with discussions of diagnosis and therapy. Follow-ups. Consecutive case conferences.

2 Basic cardiovascular physiology and pharmacology seminars.

3) Monthly "problem EKG" session.

The regular contact with the resident staff allows the cardiologist to evaluate constantly the interest, improving skills, and the weak points of the members of the group.

Our experience confirmed the conclusions of the American Heart Association Study Group, that a short period of concentrated teaching of a given skill (auscultation, for example) cannot replace the continued and repetitive exposure and constant reevaluation of the efficiency of the teaching.

Periodically, each member of the group is asked to review and discuss certain subjects (i.e., coronary circulation, pericarditis, mitral stenosis) with review of the bibliography. It is rewarding to see how a group of initially untalkative house officers can be transformed into an active discussion forum with the help of the round table and soup and sandwiches.

In addition to this year-round teaching exercise, much benefit can be obtained from the creation of a cardiac residency. For a given period (preferably not less than three months), the assistant resident may be assigned to the cardiac service under the preceptorship of an active cardiologist on the staff. During this period, the house officer is called the cardiac resident. Importantly, he retains certain ward responsibilities to maintain continuity but assumes additional duties specifically related to cardiovascular diseases. In an average community hospital, these additional duties may include:

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2) Participation in the cardiac resuscitation team as permanent member for the time period.

3) Daily interpretation of EKG's (under the guidance of the senior cardiologist).

(4) Assistance at special procedures (angiograms, cardioversion).

5) Responsibility of case material, bibliographies for the cardiac luncheon.

6) Participation in the sessions of the local Work Classification unit, allowing him considerable exposure to problems of cardiac rehabilitation.

7) If the proximity of a medical center permits suitable arrangements may be made for him to observe specialized diagnostic procedures and attend teaching conferences.

In our experience, this approach provides an adequate exposure to cardiovascular diseases in the frame of a medical residency training program. The purpose is not to educate a subspecialist but to provide sufficient stimulation and experience through individual guidance.

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EDITOR

PHYSICAL THERAPY IN MEDICAL PRACTICE

PAUL F. RICHARDSON, MD

THE RAPIDLY GROWING POPULATION of the United States will be an estimated 214 million by 1970, a scant five years away. Including the proposed new medical schools and the planned expansion of the existing ones, there will not be adequate facilities to graduate enough physicians each year to maintain the present physician to patient ratio. In order to provide adequate medical care to an increasing number of patients, the physician must become more efficient and will need to make more use of the increasing variety of ancillary or paramedical personnel. Knowledge of the skills offered by the various paramedical specialists will enable the physician to provide better medical care to a greater number of patients with less time expended by himself per patient. Among these many helpers, the nurse is the best known and most called upon. Less well known are other paramedical persons, among which is the physical therapist. A brief discussion of the role of the physical therapist in the practice of medicine is presented so that the skills of this valuable assistant can be properly used.

A physical therapist is concerned with the treatment of patients with various physical impairments so that resultant disability can be minimized or prevented. The treatment used by physical therapists consists primarily of the application of various physical agents such as heat, light, water, electricity, and mechanical devices, plus therapeutic exercise and training in activities of daily living. This treatment must be done upon the prescription of a physician. The therapist may not ethically or legally accept a patient for treatment otherwise.

In Maryland, physical therapists must be licensed before they are permitted to practice. To qualify for admission to the licensing examination, a person must be a graduate of an approved school which requires a minimum of four years of education and a baccalaureate degree. When the licensing law in Maryland was passed in 1947, a grandfather clause permitted those without such education but with experience in physical therapy to be licensed. The law entitles one who is licensed to practice physical therapy and to use the abbreviation PT or RPT after his name, signifying that he is a licensed physical therapist. Persons not licensed to practice physical therapy are not permitted to use this designation. In the listing of physical therapist, in the Yellow Pages, are a number of listings with the abbreviation *Dr.* appearing with the name, apparently indicating a doctorate level of education. To my knowledge, no academic degree at the doctorate level has ever been granted in the field of physical therapy. Persons who are physical therapists may also hold doctorates such as PhD, DSc, or EdD, but these advanced academic degrees are not granted in physical therapy and are not directly related to the practice of physical therapy. One therefore wonders what the designation *Dr.* indicates in the physical therapy listing and what the public might infer from it.

The educational requirements for physical therapy are mentioned to inform the physician of the level of competency he should expect from physi-

cal therapists and to indicate that they are not mere technicians but have a professional responsibility. The professional responsibility of the physical therapist is to see that the patient receives the maximum benefit from the prescribed treatment and preventive measures.

The physician has responsibility for the total care of the patient, and he must maintain supervision of the patient in order to be assured that the proper quality and quantity of treatment is being administered. A proper prescription for physical therapy should include the diagnosis and any precautions to be observed by the therapist, as well as the specific treatment goals. The physician's prescription may be as detailed as he deems necessary to ensure that the type of treatment and the desired responses of the patient are communicated to the physical therapist. Usually the prescription is couched in as general terms as possible so that the physical therapist is given some professional freedom in treating the patient and is not unnecessarily restricted by the prescription. In a therapeutic exercise program, for instance, the treatment can then be changed by the therapist to keep pace with improvement in the patient and to facilitate his progress. The prescription for therapy should specify the frequency of treatment which is considered to be the most efficacious or the most practical. A definite time for the patient to be seen again by the physician should be designated so that reevaluation can be done and changes made in the prescription or treatment terminated, if indicated. Some patients may require only a few treatments and others may require prolonged treatment, but the physician, by proper follow-up, is the one to decide this.

Often physical therapists can aid the physician by teaching the patient a home exercise program which can be done daily by the patient with a weekly or biweekly visit to the therapist for reinforcement of the exercise program and periodic visits to the physician to determine the effectiveness of the treatment. This type of program is particularly useful in chronic illnesses such as rheumatoid arthritis. The physical therapist can also assist in diagnosis and evaluation of patients by performing manual muscle tests, certain electrodiagnostic tests (exclusive of electromyography), and certain functional evaluations such as activity of daily living tests.

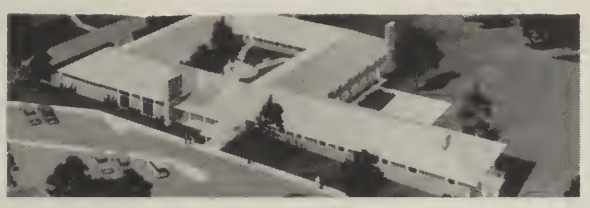
In prescribing specific treatments, such as shortwave diathermy, hot packs, massage, ultrasound, whirlpool, or electrical stimulation, the physician must be mindful of the physiologic basis for their use and the results he expects to achieve. He should also keep in mind that these modalities are often useful as preliminary measures in order to make subsequent treatment more effective. This is often the case before therapeutic exercise, which may be the major treatment indicated in a particular case. The application of heat or whirlpool may enable the patient to cooperate more fully with the exercise program. Properly selected and applied therapeutic exercise is often the most important part of the physical therapy.

The physician should be able to rely upon the physical therapist to devise specific exercises to accomplish the therapeutic result specified by the physician's prescription. However, he should personally be familiar with the various forms of therapeutic exercise, not only to know when they should be prescribed but also to know whether or not the proper specific exercises are being done by the physical therapist. More often than not, the success or failure of physical therapy depends upon the quality of the therapeutic exercise program.

In summary, the physician is responsible for the total care of the patient, and it is his duty to maintain supervision of paramedical personnel to assure that the best treatment possible is being given to his patient. He must realize that the law prohibits physical therapists from treating patients unless referred by a physician. It is, therefore, incumbent upon the physician to consider physical therapy as an important part of his therapeutic armamentarium, just as he does drugs and surgery. He must prescribe it appropriately and at the proper time rather than think of it as a last resort when its effectiveness is diminished. The physician who makes an effort to know the indications and contraindications for physical therapy and makes judicious use of it will find that his patients are the beneficiaries.

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Arthrography of the Knee

MARION C. RESTIVO, MD
Department of Radiology
University of Maryland Hospital

CONTRAST VISUALIZATION of the internal structures of the knee was first described by Werndorff and Robinsohn in 1905. Little consideration was given to this procedure until the decade between 1930 and 1940, when several excellent papers appeared describing the value of arthrography in the diagnosis of internal derangement of the knee. Lindblom's classic monograph was published in 1948, describing 4,000 arthrograms of the knee performed at the Karolinska Sjukhuset. Although the accuracy of the procedure varies from series to series, Lindblom achieved an accuracy of 95% in the diagnosis of meniscal rupture in patients subsequently undergoing arthrotomy.

Air was the original contrast material employed. In subsequent years, water-soluble, iodine-containing contrast material was developed. Some investigators have used both concomitantly, but most prefer positive contrast material alone. In comparable successive series at the Karolinska, Lindblom reported that the frequency of diagnosis of meniscal rupture diminished with gas arthrography.

Side effects are uncommon with the use of either air or positive contrast material. Occasional patients will experience a "post arthrography" effusion with air or the older positive contrast materials. Gas embolism is a danger only with the use of air. The latter method also necessitates a second arthrocentesis to remove the gas when the examination is completed. Except for the remote possibility of introducing infection into the joint, which is inherent in any of these methods, the only



Fig 1
Anteroposterior projection demonstrating the mid portion of a normal medial and lateral meniscus.



Fig 2

Anteroposterior projection in which contrast material is seen penetrating into an oblique tear in the mid portion of the medial meniscus. External rotation films demonstrated extension of this tear into the posterior horn of this meniscus.

side effect peculiar to the iodine compounds is the possibility of idiosyncratic or allergic reaction to the material.

The technique is simple and is readily performed on an outpatient basis. Mild sedation is offered to the anxious patient. Preliminary films are exposed at several angulations to "open" the joint. Arthrocentesis is performed in the usual manner. If effusion is present it is drained to prevent dilution. If no fluid is obtained, only one milliliter of sterile aqueous, iodine-containing contrast material is instilled. Pain should not occur. If it does, it indicates that the need'e tip is not positioned within the joint space. When one obtains proper communication with the joint, a total of 8-12 ml of medium can be instilled effortlessly. The needle is withdrawn and the knee manipulated briefly to insure proper distribution throughout the joint. A firm compression bandage is applied above the knee to compress the suprapatellar recess and force the contrast into the joint space proper. Films are exposed without delay, since considerable absorption of contrast material can occur in as little as 20 minutes.

The arthrogram should demonstrate the internal structures as sharply defined negative images outlined by the contrast material. The menisci are lucent masses having wedge-shaped cross sections with their apices opposed and their bases continuous with the joint capsule everywhere except posterolaterally where the bursa of the popliteous tendon interposes itself between the posterior horn of the lateral meniscus and the capsule (fig 1). Elsewhere opaque medium between the meniscus and the capsule is abnormal. The cruciate ligaments can usually be seen in the lateral projection. The anterior is longer and passes obliquely posterosuperiorly and laterally from the anterior intercondylar eminence of the tibia to the intercondylar region of the femur. The posterior cruciate ligament has its course from the posterior tibia anteriorly, superiorly, and medially to a point near the insertion of the anterior ligament.

The most common injury found by arthrography is rupture of the medial meniscus (fig 2). This accounts for approximately half of the lesions of internal derangement in most series. These tears are usually located in the posterior horn. Injuries to the medial collateral ligament are next in frequency, followed closely by rupture of the lateral meniscus and anterior cruciate ligament.

Meniscal tears are seen either as contract-filled interruptions in the integrity of these cartilages or as insinuation of contrast material between capsule and meniscus, indicating separation from their capsular attachments. The arthrographic sign of rupture of the medial collateral ligament is escape of contrast material into the para-articular soft tissues medially usually superior to the medial meniscus. A fresh tear of the anterior cruciate ligament presents as a short, irregular mass in the region of the ligament, representing a hematoma adherent to the ligament.

Occasionally a fleck of bone can be seen separated from the anterior intercondylar eminence of the tibia. This finding suggests an avulsion fracture at the insertion of the anterior ligament. If no fracture is seen, the lesion is the result of rupture of the femoral attachment of the anterior

cruciate ligament. Posterior capsular ruptures occasionally occur. These are seen as projections of contrast material extending posteriorly into the popliteal fossa. The opaque material leaks into the large irregular, intermuscular cavity. The walls become more regular with subsequent healing, but the tear may persist and the lesion fills from the joint proper. This produces a semimembranosus-gastrocnemius bursa or Baker's cyst.

Another lesion demonstrated by arthrography is a ganglion of the lateral meniscus. This lesion is rarely seen in the medial meniscus. Free bodies can be seen as lucent defects floating in the contrast material.

Hypertrophy of the infrapatellar fat pad (Hoffa's Disease) is difficult to diagnose because it depends on evaluation of size of this nebulous structure. If sufficiently large, the diagnosis can be made. Clinically, the lesion produces symptoms suggestive of meniscial injury with locking of the knee. Synovial tumors are shown as large lucent defects in the recesses of the capsule.

Accurate diagnosis by arthrography demands care in the performance of the examination and in the evaluation of the radiologic findings. Dilution of the contrast medium by failure to evacuate an effusion impedes adequate visualization. Defective filling around the menisci subsequent to failure to manipulate the knee following introduction of the contrast material is another source of error. Only those portions of the menisci which are tangential to the beam can be evaluated in any of the projections so that adequate demonstration of the entire meniscus demands internal and external rotation views in varying degrees in addition to the usual frontal and lateral projections.

In summary, positive contrast arthrography of the knee carefully performed in selected patients is often of clinical value. While technically an easy procedure, one must observe the precautions described.

Who is Responsible for Drug Safety?

The wise, and presumably safe, use of a drug depends largely on the education, training, experience and judgment of the prescriber. And to an important extent it also depends on the wisdom of the patient as he follows instructions—Austin Smith, MD, in *Experimental Medicine and Surgery*, 22:2-3, (Jun-Sep.) 1964.



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Viruses in Pregnancy

A. J. RHODES, MD
and
K. R. ROZEE, MSc, PhD

Consideration of the effects of virus infection in pregnancy would entail an evaluation of how pregnancy affects susceptibility and the eventual outcome of the disease process as well as the effect the virus has on the fetus and the events of a normal pregnancy. This article will deal with virus infection of the fetus and the neonate.

The virus which has come under closest scrutiny as a cause of fetal malformations is rubella. As judged by the absence of detectable antibodies, about one of every five or six women over 20 years of age is susceptible to rubella.[1,2] These figures apply only in the environments from which the samples were taken, mostly in North American cities. Under conditions of close contact with rubella, non-immunes are almost invariably infected with the virus. This, however, does not mean they will suffer a clinical attack. The subclinical to clinical ratio is at least 2:1; however, the severity of maternal disease appears to have little influence on the incidence of fetal malformations.

Manson's study[3] showed that in clinically ill mothers infected during the first 12 weeks of pregnancy, 5% aborted, 4.5% had stillbirths, and 6.9% of the liveborn died before two years of age. This 16.4% fetal wastage at two years may be compared to 6% wastage with mothers who had rubella after the first 12 weeks. This latter group did not have any higher incidence of fetal or infantile death than the normal control mothers.

Single or multiple defects to the heart, eye, and ear, the so-called rubella syndrome, were present in another 16% of children at the age of two years. This additional percentage slowly increased to 19-20% as latent defects, usually associated with hearing, became manifest. This excellent prospective study, therefore, gives a figure of 32-36% death or damage to products of pregnancy as a direct result of clinical rubella in the first trimester.

In the same study,[3] the effect of varicella infection on the outcome of pregnancy was assessed. No difference from a normal incidence of malformation could be found in the groups of mothers who had this disease during pregnancy. Although this coincides with the results of other workers, it does not mean that varicella is entirely without effect. Numerous reports[4] have been cited of fatal congenital or early neonatal varicella.

It has long been suspected that poliomyelitis causes a significant increase in the number of abortions and stillbirths. Aycock et al[5] cite a figure of about 25% in a series of 131 mothers. The effect of poliovirus on the fetus is lethal, and the incidence of liveborn malformed children in polio-complicated pregnancy is probably no higher than normal.

Measles in early pregnancy has been incriminated as the cause of both a higher abortion and stillbirth rate and a higher incidence of malformations.[3] The fetus does not seem to be more susceptible in early pregnancy, as it is after rubella, and the rates of both death and malformation appear lower than for rubella. As with other viruses, the hazard to the child is not confined to congenital infections. Early neonatal in-

From Department of Microbiology, School of Hygiene, University of Toronto.

fections having severe or fatal effects have been reported by many authors.[6]

The hazard to the human embryo of poxvirus infections during pregnancy is well known. It has been estimated that about 50% of pregnancies complicated by smallpox end in abortion.[7] The products of abortion from such infected mothers show widespread dermal and visceral lesions incompatible with life. In addition to the natural diseases of smallpox and alastrim, the administration of vaccinia virus during pregnancy may be detrimental to the fetus.[8] Reports in the literature cite many instances of vaccinia-induced fetal defects[9] and increased incidence of abortions.[10] Other studies, to the contrary, report that mass vaccination has no affect on the normal incidence of congenital anomalies.[11] There is ample reason, however, to consider vaccination during pregnancy an elective procedure and at least avoid the use of the vaccine during the first trimester.

Influenza in pregnancy has been suspected of causing an increase in the number of abortions and stillbirths[12] during epidemic periods. There has been no convincing evidence, however, that it is associated with congenital malformations in humans. Coffey et al[13] showed a remarkable incidence of central nervous system anomalies in children born to influenza-infected mothers during an epidemic in Dublin. However, the general high incidence of these anomalies in that area during nonepidemic times, coupled with the negative reports of others, leaves the question much in doubt.

The occurrence of abortion or stillbirth after mumps infection of the mother has been reported regularly in the literature.[4,14] The virus has also been casually associated with a variety of congenital anomalies.[15] Not enough evidence has been accumulated, however, and the association of mumps with congenital malformations is questionable.

In addition to the viruses mentioned, hepatitis, herpes simplex, and infectious mononucleosis have been incriminated as producing an increased rate of fetal wastage or congenital malformations.[4] The cases in which the infection occurred just before or at birth give rise to early neonatal disease. Infants infected at this time survive or die according to the usual pattern established for the disease in question. The problem which cannot be solved with the present data is whether or not infection of the fetus in early or middle pregnancy will result in a greater than normal incidence of malformations.

Although evidence has been found that certain virus infections have a deleterious effect on the normal processes of pregnancy and the developing human embryo, much remains to be discovered about their true importance and mechanism of action. Some of these diseases may be modified by antiserum therapy, or individuals may be entirely protected by the use of vaccines. Future work must determine the extent to which these measures protect the fetus.

REFERENCES

1. Givan, K. F.; Rozee, K. R.; and Rhodes, A. J.: Incidence of rubella antibodies in female subjects. *Canad Med Asso J* 92:126, 1965.
2. Sever, J. L.; Schiff, S. M.; and Huebner, R. J.: Frequency of rubella antibody among pregnant women and other human and animal populations. *Obstet Gynec* 23:153, 1964.
3. Manson, M. M.; Logan, W. P. D.; and Loy, R. M.: Rubella and other virus infections during pregnancy: Reports on public health and medical subjects. No. 101. HMS Stationery Office, London, 1960.
4. Blattner, R. J., and Heys, F. M.: Role of viruses in the etiology of congenital malformations. *Prog Med Virol* 3:311, 1961.
5. Aycock, W. L., and Ingals, T. H.: Maternal disease as a principle in the epidemiology of congenital anomalies. *Amer J Med Sci* 212:366, 1946.
6. Parker, A. D.: The influence of maternal measles (Morbilli) on the unborn child. *Med J Aust* 1:835, 1950.
7. Marsden, J. P., and Greenfield, C. R. M.: Inherited smallpox. *Arch Dis Child* 9:309, 1934.
8. Nardoo, P., and Hirsch, H.: Prenatal Vaccinia. *Lancet* 1:196, 1963.
9. Lynch, F. W.: Dermatologic conditions of the fetus with particular reference to variola and vaccinia. *Arch Derm Syph* 26:997, 1932.
10. MacDonald, A. M., and MacArthur, P.: Foetal vaccinia. *Arch Dis Child* 28:311, 1953.
11. Greenberg, M., et al: The effect of smallpox vaccination during pregnancy on the incidence of congenital malformations. *Pediatrics* 3:456, 1949.
12. Campbell, W. A. B.: Influenza in early pregnancy: Effects on foetus. *Lancet* 1:173, 1953.
13. Coffey, V. P., and Jessop, W. J. E.: Maternal influenza and congenital deformities. A prospective study. *Lancet* 2:935, 1959.
14. Ylinen, O., and Jarvinen, P. A.: Parotitis during pregnancy. *Acta Obstet Gynec Scand* 32:121, 1953.
15. Granvall, H., and Selander, P.: Some virus diseases in pregnancy and their effects on the fetus. *Nord Med* 37:407, 1948.

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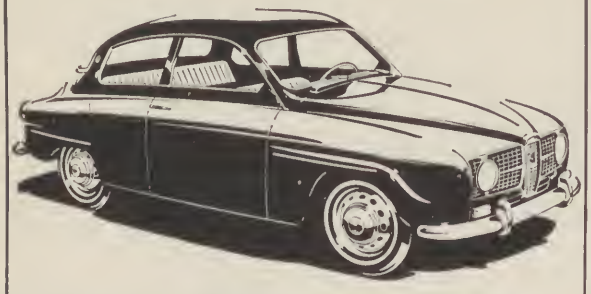
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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 2: Infected Abortion

THE PATIENT WAS A 17-year-old primigravida; estimated date of confinement from past history not known. She was admitted to the hospital in critical condition on November 15 at 3:20 AM. On questioning, she said that approximately 20 hours before admission she had taken by mouth an unknown quantity of turpentine to produce an abortion.

Physical examination on admission revealed marked dehydration in an uncooperative lethargic patient. Blood pressure was 80/68, respirations 44 per minute, pulse rate 146 per minute, and temperature being 101°. Abdominal examination revealed a lower midline mass, presumably uterus. Hemoglobin was 11.7 gm and leukocyte count 7,400. There was moderate vaginal bleeding.

Intravenous fluids and massive doses of antibiotics were begun, and she received whole blood by transfusion. Five hours after admission she spontaneously delivered a small macerated fetus with necrotic foul-smelling placenta. Cervical culture later revealed *B. Proteus* that was sensitive to Chloromycetin and Mandelamine. In spite of the treatment, her course was rapidly downhill; and in spite of oxygen by mask and intravenous Neosynephrine, respirations ceased approximately 24 hours after admission.

Following were the major positive postmortem findings: The uterus was enlarged, measuring 13 by 12 by 7 cm. The serosal surface of the uterus was covered by a fibrinous exudate with localized peritonitis. The uterine cavity contained a large amount of clotted, foul-smelling blood, and the endometrium was ragged and shaggy. The cervix measured 4 by 5 cm. The tubes and ovaries showed hemorrhage of the serosa.

The lungs revealed scattered red-brown granular areas of the lower lobes, which on section revealed extensive bronchopneumonia of both lower lobes. Cause of death was listed as septic abortion.

COMMENTS

This case is reported not because of its unusual features but because this type of case still remains all too common. The history that is usually obtained in this type of case is vague and leads to speculation. Rarely is the full story available, but the committee usually assumes, as it did in this case, that some type of mechanical interference of the pregnancy had been performed. In recent years in Maryland, at least 80-90% of all maternal deaths due to infection have been in cases of this type.

The committee considered this to be a preventable maternal death, with the responsibility laid to the patient for either having performed or sought mechanical interference to produce abortion.



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THE CITY OF BALTIMORE has a high incidence of tuberculosis, compared with other major cities in the United States. Provision of drugs without cost for tuberculosis patients and persons exposed to tuberculosis has become an established procedure of health agencies. In Baltimore City, resident patients have been receiving drugs without cost since 1951. The City Health Department now provides chemotherapeutic agents to tuberculosis patients, tuberculin reactors, and other persons with high risk exposure for both prevention and treatment. Drugs are issued to persons under adequate medical supervision of a private physician, health department chest clinics, or outpatient clinics of general hospitals.

REQUIRED PROCEDURE

1. Physicians should submit written requests for private patients who, in his judgment, are medically indigent.

2. Requests from general hospital clinics should stem from the chief of clinic.

3. Requests should be directed to the Bureau of Communicable Diseases, Baltimore City Health Department, 231 E Baltimore Street, Baltimore, Md. 21202.

4. Requests should identify the patient by name, address, age, diagnosis, extent, activity, bacteriologic status and, in children, the weight and the Mantoux test (intermediate strength PPD) in millimeters.

5. The following drugs are available: isoniazid (INH), sodium para-aminosalicylic acid (PAS), and in some cases pyridoxine (vitamin B_6) and streptomycin sulfate (SM). Physicians should feel free to discuss the matter of drug treatment with the Department's Director of Communicable Diseases.

6. The physician or clinic will be expected to notify the Bureau of Communicable Diseases (see item 3 above) in writing of any changes on patient's status or any change in dosage of drugs; also, to complete all items on a brief patient progress report, which will be mailed to him at six month intervals, and to return it to the Health Department promptly in the envelope enclosed.

7. The Health Department will assume responsibility for notifying the physician when patients fail to appear for drugs as instructed by him; but at the same time, it is most important for the physician to notify the Health Department if the patient does not continue under medical supervision.

8. Drug requests are subject to review by the bureau director or the clinical director.

Physicians are encouraged to use the x-ray and consultation facilities of the Health Department clinics as well as the services of the departmental laboratories in the bacteriologic examination of sputum or other exudates. Additional information may be obtained by calling James E. Peterman, MD, director of the Bureau of Communicable Diseases, telephone Plaza 2-2000, extension 314.

Robert E. Farber, MD
Commissioner of Health



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Highlights

REGISTRATION OF RADIATION DEVICES AND SOURCES

Users of radiation devices and sources are reminded that they must register with the Maryland State Department of Health. Regulations requiring such registration have been in effect since January, 1964, and the State Board of Health and Mental Hygiene is charged by state law with obtaining compliance.

All potential users were notified by direct mail, after adoption of the regulations, and were asked to return a card specifying whether or not they use radiation devices or sources. Subsequently, a registration blank was mailed to all who indicated that they are users and therefore subject to the state regulations. Approximately 30% of the known radiation producing equipment or sources in the state still is unregistered. Return of the registration form is necessary; response to the first query does not constitute registration.

Registration, for which there is no fee, consists of filling out a one-page form which can be completed in a few minutes. Registration must be repeated every two years, and reregistration will begin in January, 1966. If, after registration, the owner plans to move his equipment to another location, acquires new equipment, or modifies existing equipment, the Health Department must be notified.

Blanks for registration may be obtained from the radiation protection section of the Maryland State Department of Health in the State Office Building, Baltimore.

COMMUNICABLE DISEASE REPORTING

The Commissioner and the chief of the Division of Epidemiology are meeting with representatives of the Medical and Chirurgical Faculty to develop a means to obtain more complete and prompt reporting of communicable diseases, particularly syphilis, gonorrhea, tuberculosis, and hepatitis. The list of reportable diseases may be revised to simplify reporting procedures for physicians.

GUTHRIE SCREENING PROGRAM PROGRESS

The 35 hospitals now voluntarily participating in the Guthrie screening program for phenylketonuria deliver 81.4% of the total number of births in the state. Applications from several other hospitals are being processed. Three cases of PKU have been detected through this program since it was started in Maryland. New regulations resulting from HB 895 (requiring screening for PKU) will be circulated to all physicians and hospitals in Maryland.

PACKAGED DISASTER UNIT AT MONTEBELLO

A 200-bed packaged disaster hospital was prepositioned at Montebello State Hospital this month by the Division of Health Mobilization as one aspect of its program to assure the continuation of adequate health services in the event of a large scale disaster. The unit, valued at $45,000, is one of 750 new hospitals currently being prepositioned throughout the country by the Public Health Service. Situated to augment the disaster capability of Montebello State Hospital, this new packaged hospital brings to 35 the number of such units located in the state.

OCCUPATIONAL THERAPY ASSISTANTS TRAINING PROGRAM

In the current occupational therapy assistants training program, the length of the training has been increased from 16 to 20 weeks, and the course content has been expanded to include psychiatry and pediatrics. Trainees now have nine

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FEDERAL INSPECTION OF LABORATORY ACTIVITIES

Periodic federal inspections demonstrate the necessity for the state to maintain laboratory functions adequate to place Maryland's products safely in interstate commerce and constitute a significant review of laboratory capabilities. For many years, dairy products have been under surveillance, and an effective system of dairy laboratory accreditation has been established. In 1963-64, laboratory studies of shellfish bacteriology were conducted in shipments from Maryland to New York. Last year, and again last month, the various sites in the Bureau of Laboratories where bacteriology of shellfish water is performed were inspected in detail by specialists from the Public Health Service. No major deficiencies have been reported. Another inspection in the future will survey capabilities of the laboratory to test public water supplies used on interstate carriers, including ships, to provide bacteriologically and chemically acceptable water.

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Department of Mental Hygiene

Reported Primary Diagnosis	Number of Admissions 1964	1962	1960	Per cent Voluntary 1964	1962	1960
Alcoholism	2,449	1,785	1,161	44.4	44.4	20.4
Psychoneurotic reactions	621	424	248	53.6	52.8	28.6
Other personality disorders	655	410	384	42.9	34.4	13.0
Schizophrenia	1,892	1,738	1,395	21.2	19.2	6.6
Other psychotic disorders	426	354	279	38.5	33.6	11.5
Disorders related to old age	785	730	542	4.1	5.9	1.8
Mental retardation	200	157	89	14.5	10.2	3.3
All others	843	623	542	19.2	13.2	10.1
Total admissions	7,871	6,221	4,640	31.6	28.1	11.9

VOLUNTARY ADMISSIONS

THE NUMBER OF PATIENTS who were self-admitted to Maryland's psychiatric hospitals reached a record 2,491 during the 1964 fiscal year. This was 31.6% of all admissions and represented an increase of 233 over the previous year's comparable figure. The number of voluntary admissions has more than quadrupled in the last four years.

The Table shows the close relationship between reported diagnosis and type of admission. Although the proportion of voluntary admissions has gone up substantially in all diagnostic groups, major variations continue to exist. For example, half of the psychoneurotic and four out of every 10 of the alcoholic admissions were voluntary, but only 4% of geriatric patients were self-admitted. Among the important factors related to type of admission were:

1. *Previous hospitalization status.*—30.9% of first admissions and 33% of readmissions were voluntary. Excluding alcoholics, the percent voluntary was 26 among first admissions and 24.7 among readmissions.

2. *Place of residence.*—31.7% of Baltimore City admissions, 35.7% of admissions from the four suburban counties, and 26.9% of admissions from the rest of the state were voluntary.

3. *Length of hospitalization.*—The median length of hospitalization of voluntary admissions was substantially lower than the comparable time period for all other admissions.

4. *Race and sex.*—The per cent of voluntary admissions was 37.1 for white males, 31 for white females, 23.2 for nonwhite males, and 25.3 for nonwhite females.

These data indicate that an increasing proportion of patients are entering the psychiatric hospital of their own volition. Most admissions now are for short term treatment of acute disturbances.

Kurt Gorwitz



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NEW BILLS FOR SUPPORT OF MEDICAL LIBRARIES IN CONGRESS

A BILL AUTHORIZING THE NATIONAL LIBRARY of Medicine (NLM) to make grants-in-aid for the support of the nation's medical libraries was introduced on January 19 by Senator Lister Hill of Alabama and Representative Oren Harris of Arkansas. Called the *Medical Library Assistance Act of 1965* (Senate bill S597 and House bill HR 3142), the bill would expand NLM's activities by $112.5 million over a five-year period. It would authorize grants to pay part of the cost of constructing medical libraries and for initial acquisition of medical library resources, including books and journals.

The bill would also authorize matching grants for library resources over a five-year period up to a maximum of 60% of federal funds for the first year, 50% the second year, 40% the third year, 30% the fourth year, and ending with 20% for the fifth year. Matching grants to a maximum of 75% of federal funds would be authorized for construction.

The bill would also permit grants for the training of medical librarians and other information specialists in the health sciences, support research in medical librarianship and related medical communication fields, support fellowships, provide financial support to biomedical scientific publications, and provide for grants-in-aid to regional medical libraries. Research and training grants would be made to appropriate public and private nonprofit institutions.

Grants to medical libraries to serve as regional centers would be made according to geographic consideration in relation to concentrated need by scientists, teachers, and physicians, so that they would have better access to the medical literature.

All grants would be made formally by the Surgeon General of the U. S. Public Health Service through the National Library of Medicine, whose Board of Regents would assist the Surgeon General in the preparation of general regulations and with respect to policy matters arising in administering the program.

Interviewed recently, Medical Library Association President Estelle Brodman said, "This is a vitally important matter to all medical libraries, and I know we will all wish to do our utmost to bring about the passage of this legislation." Asked how this could be done, she suggested calling, writing, and talking to our senators and representatives. She also suggested asking hospital superintendents, deans, medical society officers, and others interested in the well-being of the population and continued research into medical problems, to make their views known to the legislators. As a group, also, the Medical Library Association hopes to testify at hearings on these bills and explain how important it is to the country that this legislation be enacted promptly.

—MLA News, February, 1965

By this time these two bills may be history, as the hearings were expected to occur in late April. However, since delays in the legislative process are unpredictable, it might not be too late to con-

tact your own senators and representatives or write to the sponsoring legislators, Senator Hill and Representative Harris.

RECENT ACCESSIONS

Bates, David V.: *Respiratory function in disease,* Saunders, 1964.

Behrens, Charles F.: *Atomic medicine,* ed 4, Williams & Wilkins, 1964.

Blodi, Frederick C.: *Stereoscopic manual of the ocular fundus in local and systemic disease,* Mosby, 1964.

Burch, George Edward: *A history of electrocardiography,* Year Book Medical Publishers, 1964.

Commission on Drug Safety Report, Federation of American Society for Experimental Biology, 1964.

Dewhurst, Christopher J.: *Gynaecological disorders of infants and children,* F. A. Davis Co., 1963.

Farndale, James (ed): *Trends in the National Health Service,* Pergamon, 1964.

Krugman, Saul: *Infectious diseases of children,* ed 3, Mosby, 1964.

Life insurance fact book, 1964.

Miller, Frederick J. W.: *Tuberculosis in children: evolution, control, treatment,* Little, Brown, 1963.

Millspaugh, Charles F.: *American medicinal plants,* Boericke & Tafel, 1887.

National Congress on Voluntary Health Insurance and Prepayment, 3, Chicago, February, 1963, A.M.A., 1963.

National Library of Medicine: *Bibliography on smoking and health, 1958-1963,* U. S. Public Health Service, 1963.

Speer, Frederic: *The allergic child,* Harper & Row, 1963.

Zimmerman, Leo M.: *Physiologic principles of surgery,* ed 2, Saunders, 1964.

Directories

American Academy of Ophthalmology and Otolaryngology: Directory, 1964.

Hospital Council of Maryland, Inc.: Directory of Maryland Hospitals, 1965.

Medical Manpower

Maryland Commission to Study the Shortage of General Practitioners, 1964.

American Medical Association: Circulation and Record Department. Directory report service. Quarterly tables of distribution of physicians by type of practice. AMA, 1961 to present.

Yearbooks and Manuals

Yearbook of dentistry, 1964/65.

Yearbook of drug therapy, 1964/65.

Yearbook of general surgery, 1964/65.

Yearbook of radiology, 1964/65.

Yearbook of pediatrics, 1964/65.

Current therapy, latest approved methods of treatment for the practicing physician, 1965.

U. S. Government organization manual, 1964/65.

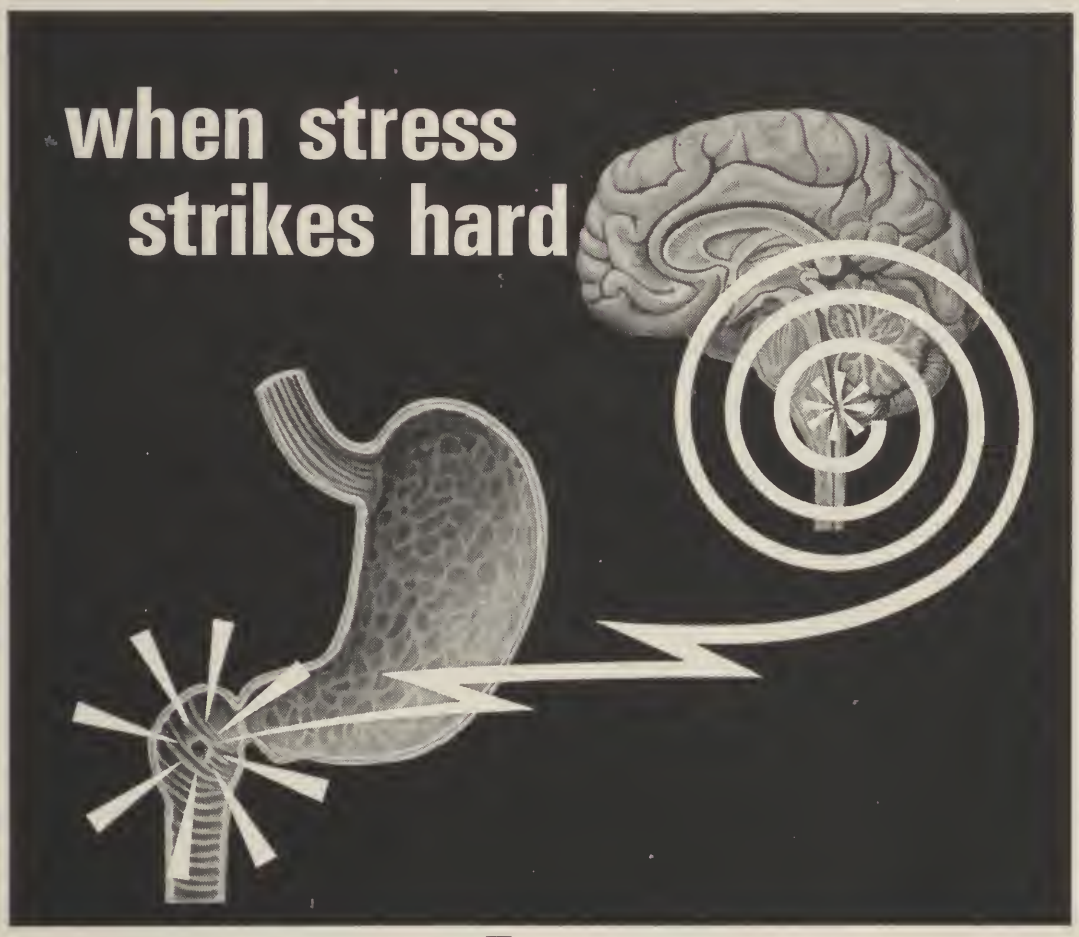
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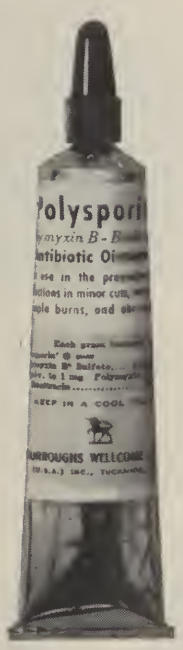
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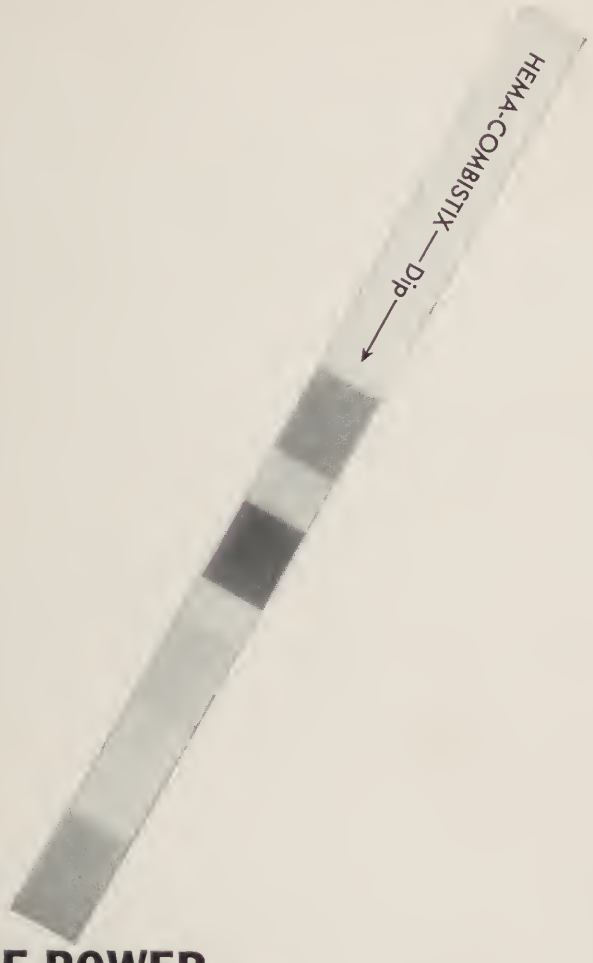
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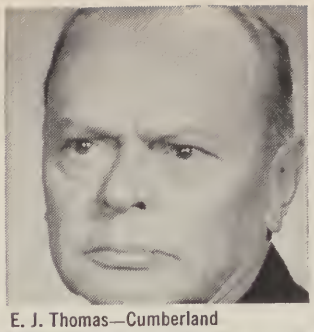
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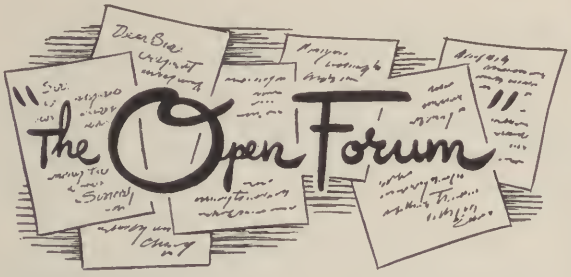
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To The Editor:

Recent actions taken at special and regular meetings of our parent State Medical and Chirurgical Faculty and its components are of great concern to all Maryland doctors. Under present circumstances, the profession can express its statewide desires and directives only by resort to the Forum of the editorial pages of our *State Medical Journal;* and act only by having special meetings of the component societies, preceding the September session at Ocean City.

Consultation with our Parliamentarian, Mr. J. W. Evans, concerning the powers and duties of the governing body or bodies of our State Society brought forth the opinion that our elected delegates are the equivalent of a committee or board; and have to follow voted instructions by the electing and instructing voting members. Pursuant to this, the delegation ordinarily delivers its instructions to the Chairman of the meeting, who records them. When voting comes in the order of parliamentary procedure, if the delegates do not follow the instructed voting, the Chairman of the meeting records only the instructed votes of the component society. If delegates do not intend to carry out the instructions of the component society voters when at the State Society meeting, they should resign at the component meeting. Any resultant voting contrary to this procedure, is, to say the least, legally questionable.

If one considers our governing body, the House of Delegates, as constituting an elected committee or board, its members are committee or board members.

1. Our Bylaws should specifically state if the House of Delegates is to be our governing body and the elected delegates to act as members of a directors' board or committee; or of a House of Delegates-committee or board.

2. The Bylaws should specify that only the members of this committee or board are voting members of the Medical and Chirurgical Faculty, with authority and power to determine and con-



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trol nominations and elections of officers, committees, boards; dues, assessments; policies, and the very existence of our societies.

3. That all other active members are voting members only of the component societies and not of the parent Medical and Chirurgical Faculty, having no rights, authority, control, decisions, or votes in the nominations and elections of officers, committees or boards; dues, assessments; policies and the very existence of the societies themselves.

4. If all other members are voting members of both societies, the Bylaws should so specify in billing, as our present dues bills state (rightly or wrongly), we are members in good standing of both societies.

5. If this governing body is a committee or board, our Bylaws, according to statutory corporation law, should specify which voting members of the Medical and Chirurgical Faculty may direct this committee or board to carry out their wishes by personal or proxy voting under corporate law. If the active members of our State parent organization are not voting members both of the Medical and Chirurgical Faculty and the component societies, our Bylaws should specifically state this, so we may govern ourselves and act accordingly toward the election and removal of members of the governing board or committee, under whatever title they assume—delegates, directors, etc.

Under Statutory Law, the legal tenure of office for directors is not perpetual, but at the most five years, part of the directors' terms ending each year. In other words, is it legal for our delegates or directors once elected under present Bylaws, to exclusively control the organization for better or worse; and for practical purposes, perpetuate themselves?

As proxy voting can only be exercised by voting members of non-stock corporations, such proxies cannot be exercised by non-voting members in the organization, or outsiders, but must be given to voting members, according to Robert's Parliamentary Rules. See Bylaws.

The following questions must ultimately be solved:

1. Can the active members legally sign away all their rights and voting membership in the parent society—the Medical and Chirurgical Faculty (as well as control of the very existence of the Medical and Chirurgical Faculty) perpetually to

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the House of Delegates?

2. Have they already done so?

3. If this were the original purpose and intent of the organization, would not the charter and Bylaws have definitely stated that membership voting in the Medical and Chirurgical Faculty is restricted to the House of Delegates' members only? Are there any other actual members of the Medical and Chirurgical Faculty; or, are the members of the board (House of Delegates) the only members of the corporation?

4. Do not the Bylaws contradict themselves when they deny proxy voting to component societies in the absence in person of component society delegates and alternates, as in the present Bylaws?

5. Is not a vote taken under these circumstances and conflicting with the Bylaws illegal?

6. Is preferred membership, particularly among active members in a non-stock corporation legal, when applied to votes for State Board of Examiners, in contrast to others?

7. Is denial of personal and proxy voting to active members in good standing of the Medical and Chirurgical Faculty, the parent organization, in conflict with Maryland Statutory Law?

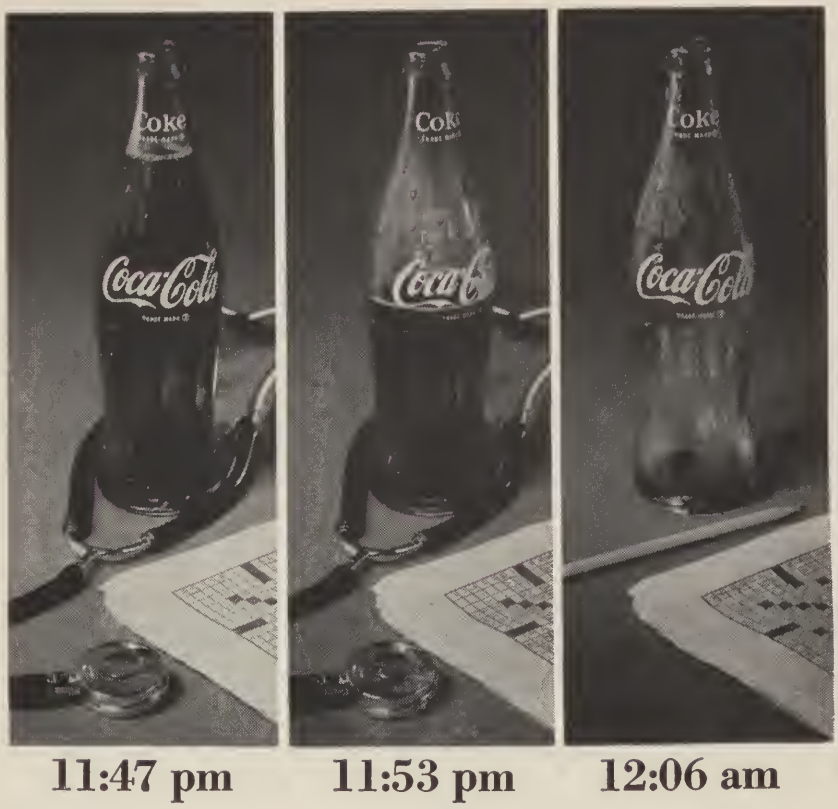
If voting in person or by proxy was not a legal and accepted method of voting by our non-stock corporation in 1904, when our Bylaws were changed, why would this highly intelligent group of our law abiding members have even deigned to mention it, discuss it, and vote it down at all? Why in Maryland Statutory Law on non-stock corporations do the chapters on voting, specify "members in *person or by proxy*," if proxy voting is not intended here?

We must be mindful of the fact that while living in the present, all of us are a living part of the past and future; and must decide the goals and purposes of our medical societies, for whom and by whom and how they will be carried out.

Our *Journal* might well give full and free play to statewide membership opinion and suggestions to determine if they are satisfied with the present situation and what actions, if any, they suggest before the September session.

M. B. Levin, MD

(Editor's Note: Dr. Levin's contentions were tried in Baltimore City's lower court and on appeals to the superior court of Baltimore City and the court of appeals, Annapolis. A verdict



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in favor of the Baltimore City Medical Society and the Medical and Chirurgical Faculty was upheld.)

To The Editor:

On April 7, at noon, 30 physicians of a newly organized Physicians for Automotive Safety made a "dignified protest" before the 1965 International Automobile Show at the New York Coliseum. Fourteen specific objections to current automobile design were indicated on the placards which the physicians carried. Since the protest, the response from the public and our fellow physicians reflects sentiment that our action was long overdue. Despite past intensive programs directed at control of the environment (the highway) and the host (man), little attention has been directed towards preventive countermeasures for the specific agent (the automobile). Defective automobile design is responsible for much of the epidemic injury, disfigurements, and disabilities.

All the previous resolutions of the American Medical Association and the American College of Surgeons asking that the industry make a safer car have been almost completely ignored. There will be no conflict with the regular medical organization activities on automotive safety, and the Physicians for Automotive Safety will cooperate to reinforce the mutual objective.

The Physicians for Automotive Safety, as a smaller and more flexible organization, will direct programs specifically to effecting occupant protection in motor vehicles. Physicians for Automotive Safety represents the first attempt at organization of the practicing medical profession to cope with a known mechanical epidemiologic agent. The nature of the present epidemic clearly justifies this approach.

Membership inquiries and suggestions for future action should be directed to Dr. Arnold Constad, Secretary-Treasurer, 527 Morris Avenue, Springfield, New Jersey. Basic membership fee is $5, contributing membership $15, sustaining membership $25 per year. Hopefully, physicians from every section of the country will join to give meaningful influence for this new medical group.

Seymour Charles, MD, President
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EXECUTIVE SECRETARY'S NEWSLETTER

July, 1965

WORK PERMITS FOR MINORS

Work permits for minors may be issued by any licensed and registered physician in the state. If any physician encounters any difficulty in acceptance of these work permits by labor department officials, please let the Faculty office know.

SEMIANNUAL MEETING

Friday, September 10, is the date of the Semiannual Meeting in Ocean City, Maryland. The Commander Hotel is headquarters. It isn't too early to make your hotel reservation now.

Other groups meeting jointly with the Faculty include:

Maryland Chapter, American College of Surgeons
Maryland Diabetes Association
Maryland Psychiatric Society
Maryland-District of Columbia Society of Anesthesiologists

Representatives will be on hand to make reservations for the Bermuda Cruise, which is part of the 1966 Annual Meeting. Full details will be available at the Ocean City meeting.

INDIVIDUAL PHYSICIANS MAY TESTIFY ON AMA MATTERS

Contrary to what most physicians believe, it is permissible and highly desirable that individual physicians express their opinions on matters that are under discussion by the American Medical Association's House of Delegates.

All matters are referred to Reference Committees where they are discussed in detail. Individuals, as well as physician-members of the AMA, are encouraged to speak on matters in which they are interested.

Remember, the clinical session of the AMA is scheduled for Philadelphia, Pa., November 28 - December 1.

PROFESSIONAL TITLES

"A source of confusion to the public is the indiscriminate use of the "doctor" title. In the health field, the use of the title "doctor" by

persons without a doctor's degree from a recognized medical or dental school not only misleads the public but debases the worth of the degree earned by rigorous education in the universities. This situation should be corrected by restricting the use of the doctor title in the health field only to those to whom it had been awarded by recognized universities."

- - from Canadian Royal Commission on Health Services report.

NEWS NOTES

Henry P. Laughlin, M.D., Bethesda, has received a gold medal from the American College of Psychiatrists for "his achievements and leadership in Psychiatry."

This is the first such Gold Medal Award by the College. Dr. Laughlin was College President in 1963-65.

Johns Hopkins University School of Medicine has received a $15,000 gift from Smith, Kline and French for support of "Department of Pharmacology and Experimental Therapeutics" - This is the first of three.

The Maryland Psychiatric Society cruised the Harbor on the Port Welcome in May when about 50 couples participated in this first social event of that group. It is planned to continue this activity.

Arthur G. Siwinski, M.D., has completed his two weeks Army Reserve Training at Fort Sam Houston, Texas.

Robert J. Mahon, M.D., has relocated his office at the Hampton House Apartments, Towson

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The John Archer Diploma, the first medical school diploma ever issued in the United States, is on loan to the University of Pennsylvania Medical School on the occasion of its 200th anniversary.

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John Sargent

Executive Secretary

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EXECUTIVE COMMITTEE, MAY 27

1. The Executive Committee agreed to share the cost of the TV series sponsored by the Baltimore City Medical Society providing that appropriate credit was given the Faculty. This is to be referred to the Public Relations Committee to consider whether this is an appropriate charge against the funds collected for the educational program.

2. A list of names was approved for recommendation as chairman of the Maryland State Advisory Committee to the Selective Service System.

3. Various letters were received concerning the corporate practice of medicine. Some questioned the legality of the Faculty's action, some asked for clarification of their own position, and others reported that they were attempting to negotiate an ethical contract.

4. Cosponsorship of an alcoholism seminar for Bethlehem Steel Company management and safety personnel was approved. Other cosponsors are the State Department of Mental Hygiene, Baltimore City Health Department, and the Baltimore Area Council on Alcoholism. There will be no cost to the Faculty.

5. The Faculty librarian is participating in an AMA committee on Information Needs of the Practicing Physician. More about this will be found on the Library page.

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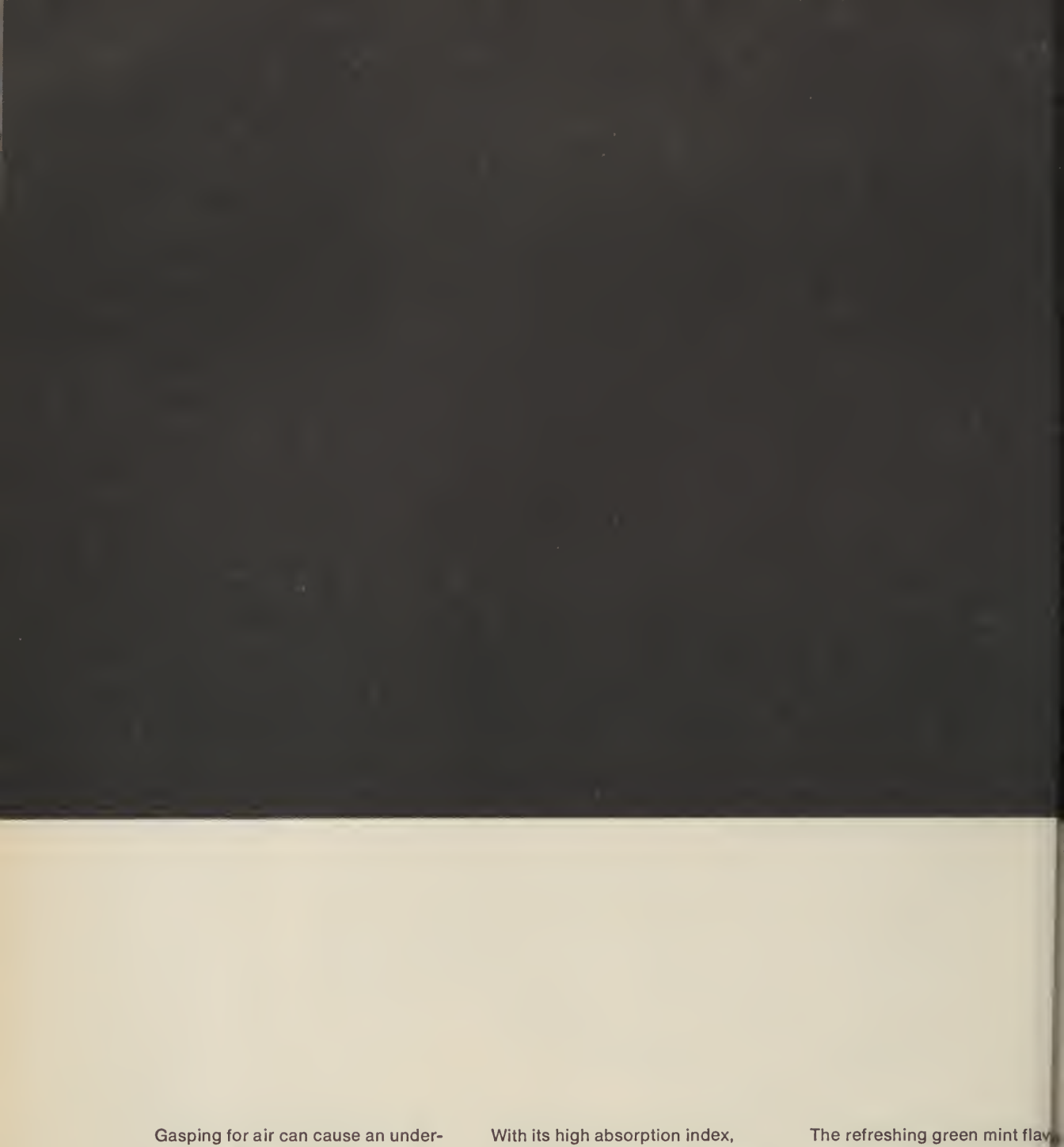
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House of Delegates—Friday, September 10, 9:30 a.m.

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Friday, September 10, 12:30 p.m.

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POPULATION CONTROL

Where does the physician fit in?

Some facts of the population problem as they pertain to the now and the future and some steps that we as physicians might take to solve the problem within a reasonable period.

FRANKLIN T. BRAYER, MD
Director, Center for Population Research, Georgetown University

ONE OF MAN'S GREAT ILLUSIONS is that all of his rational acts are carried out in such a way as to insure the best possible consequences to himself. History belies the illusion.

Until the nineteenth century, man's illusions about the consequences of his reproductive acts were of little concern. A high birth rate was effectively balanced by a high death rate, and the almost imperceptible growth in population was viewed as no cause for alarm.

Suddenly, however, a change, which was to upset drastically the near equilibrium between birth and death rates was introduced; namely, the miracle of modern medical science. Death rates in the western world began to plummet in the latter part of the nineteenth century. Death rates in the rest of the world were slower to fall, but the wide dispersion of modern public health measures during and after World War II rapidly affected death rates everywhere.

In 1850, the crude death rate* in Denmark was 18; by 1960 it was 9. In 1900, the death rate in Ceylon was 28; in 1940 it was 20; but by 1960 it was 9.[1] This dramatic drop was due to public health measures introduced after World War II. A similar story about death rates can be told for almost all, if not all, of the other countries of the world.

While the death rates in the western world plunged, the birth rates only slowly declined, beginning in the 1870's and falling to all-time lows during the great depression. In the United States it reached a record low of 17.2 in the 1931-40 period. In the underdeveloped nations, birth rates of 30 or more persist to this very day. Since World War II, there has been an upturning of birth rates in many of the countries of the western world, hovering around 20.[2]

The widening difference between death rates and birth rates, particularly in the underdeveloped areas of the world, which is directly attributable to modern public health measures, has brought about the present dilemma of population.

The present population of the world is estimated at 3.2 billion. In approximately 15 years, another billion will be added; and by 2000 there will be more than seven billion people on earth, if the present rate of increase of 1.7% is not significantly lessened.

For just a moment let us consider some of the consequences of the present annual rate of increase.

Using the exponential equation $A = Pe^{\frac{rt}{001}}$ familiar to all investors, some relevant numbers can be calculated:

1. At the present rate of increase, the world's population doubles every 40 years.
2. In a period of time less than the age of the United States, there would be 160 billion people on earth.
3. In about 800 years, there would be standing room only in the United States.[3]

I. Ridgeway Trimble Fund Lecture presented April 21, 1965, at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

*Crude death rate is deaths per 1,000 of population per year.

These last two points are obvious absurdities, because long before these numbers were realized the Four Horsemen of the Apocalypse would have prevailed.

The impossibility of sustaining the present rate of increase can be viewed from another perspective.

There are 60 million square miles of land on this earth. Of this amount, 16 million square miles are inhabitable by man. One hundred and fifty thousand square miles are presently occupied by settlements. If the present rate of doubling of the population persists, in about 200 years, eight million square miles, or half the available inhabitable land, would be occupied by settlements.[4] Unless some miraculous way of growing edible food in space is discovered, such an eventuality is, likewise, an absurdity.

Let me cite several other sets of figures to fix in your minds the enormity of the problems of our expanding population.

At the beginning of the twentieth century, the United States used 40 billion gallons of water every day. By 1965, 359 billion gallons were being used daily. In the year 2000, the daily consumption of water in the United States will be 880 billion gallons. This huge estimated increase in use by 2000 is bad enough to contemplate, but when one realizes that only 515 billion gallons per day will be available from conventional sources, the whole picture becomes decidedly askew.[5]

About half the people in the world today are underfed. According to the United States Department of Agriculture, if an adequate level of nutrition is to be supplied all peoples of the world, the production of food will have to be tripled by 2000.[6] Only the most incurable optimists see any likelihood that this projection will be accomplished.

With these ominous statistics before us—many others could be quoted—it is only natural to ask: "How did this state of affairs develop, and what can be done about it?"

Most population experts would answer the first question by pointing out that one of the major contributing causes to the present problem of overpopulation has been the all too efficient use of modern medical measures throughout the whole world. You, the physician, have been so eminently successful in your attack on disease that literally millions of babies who as few as 15 years ago would not have survived to puberty now are living to grow into adults capable of adding their bit to the problem of overpopulation.

Those miracles of modern medicine that have allowed for survival of so many have not been matched by commensurate measures capable of controlling fertility willfully. And it is to the second question that I now wish to address myself.

If meaningful and significant reductions of the rate of increase are to be made, then far more effort must be expended worldwide to further willful control of fertility. As physicians we are morally obligated to make every use of our unique position in the community to promulgate the absolute need for willful fertility control throughout the world. While I am sure that there are innumerable ways of furthering the solution of the willful control of fertility, the following ideas have occurred to me.

First is the great need to inform all peoples of the world, not only at governing levels but right down to the grass root levels, that there is a serious problem of overpopulation that is worldwide in scope; that if the problem is not solved, the consequences may be catastrophic; that all peoples of the world must cooperatively seek a meaningful and acceptable solution; and that the effort expended in solving this problem is the joint responsibility of all nations, not just the developed nations.

Second, because the problem of unbounded fertility has some peculiarly unique relationships to medicine, it is mandatory that physicians take upon themselves the responsibility of emphasizing to their respective governments, through their own private efforts and through the concerted efforts of their professional societies, the great and pressing need for using all acceptable means at hand for controlling fertility in their respective countries. Efforts along these lines to date, while commendatory, are hardly adequate to the situation.

Third, the governments of the rich nations, such as ours, must be made to realize that a crash type research program supplied with unlimited funds is a must, right now, if the problem of population overgrowth is to be contained by humanitarian means.

Who, I ask you, is in a better position to bring such a program into being than you, the physician?

Funds presently available for research in reproduction and fertility control are totally and shamefully inadequate.

If this great government of ours could respond to the surprise and shock of a Russian sputnik by designating within a few months' time, literally, billions of dollars to insure our equaling or surpassing the Russian space effort, it is hardly out of the realm of the possible to suggest, to expect, yes! even to demand that the same government come to realize the seriousness of the population problem and act in a fashion commensurate with the magnitude of the problem. I am thinking here of the funds needed for finding better ways and means of controlling fertility than are now available, to say nothing of the funds needed for finding the ways and means of coping with and solving all the ancillary problems resulting from too many people.

I do not mean to deny the impressive statistics of such methods of fertility control as the synthetic progestins and the intrauterine devices; but if these methods are the best modern science can provide, then I, for one, feel that there is little to brag about. The "pills," as you know, while effective, are much too expensive to be considered for worldwide use even if they do become universally acceptable. The intrauterine device, while cheap and effective, is a device—a device that must be in place to be effective. On the basis of esthetic considerations, to say nothing of moral grounds, I find it difficult, if not impossible, to foresee the day when all the women in the world of reproductive age will wear within themselves for 20 or more years a gadget to control family size. "Surely, we physicians can do better than that for our women."

Basic to fertility control is a better and deeper understanding of man's sexuality. Research in this highly emotional, highly complex, and highly mysterious aspect of man's nature is particularly and singularly the province of the physician; yet research in this area is in its infancy. Even physicians have astonishingly naive concepts about the role of sex in the affairs of man.[7] Only properly supported research will help us to gain a better understanding of our sexual nature. Right now, more money is spent on the trash that fills our newsstands and bookstores than is spent on research on sex. We need to know not how to describe in more titillating terms how Don Juan arrives at a new conquest but rather why he wants to in the first place.

Research and more research conducted by qualified professionals in properly equipped facilities will provide the answers.

Fourth, you, the individual physician, have a personal responsibility in this matter, that cannot be delegated, to acquaint yourselves with the nature and scope of the problem of population. You are obligated to be prepared to deal adequately and knowledgeably with the problem of fertility control within the privacy of your office whenever your patients seek your help and advice in this matter. The way in which you handle the matter at the source will determine in no small measure the way in which this country will eventually handle the problem.

Shall we resort to abortion to keep our numbers within reason, or shall we be able to control them in a fashion that is morally, esthetically, and professionally satisfactory to all? The answer is in your hands.

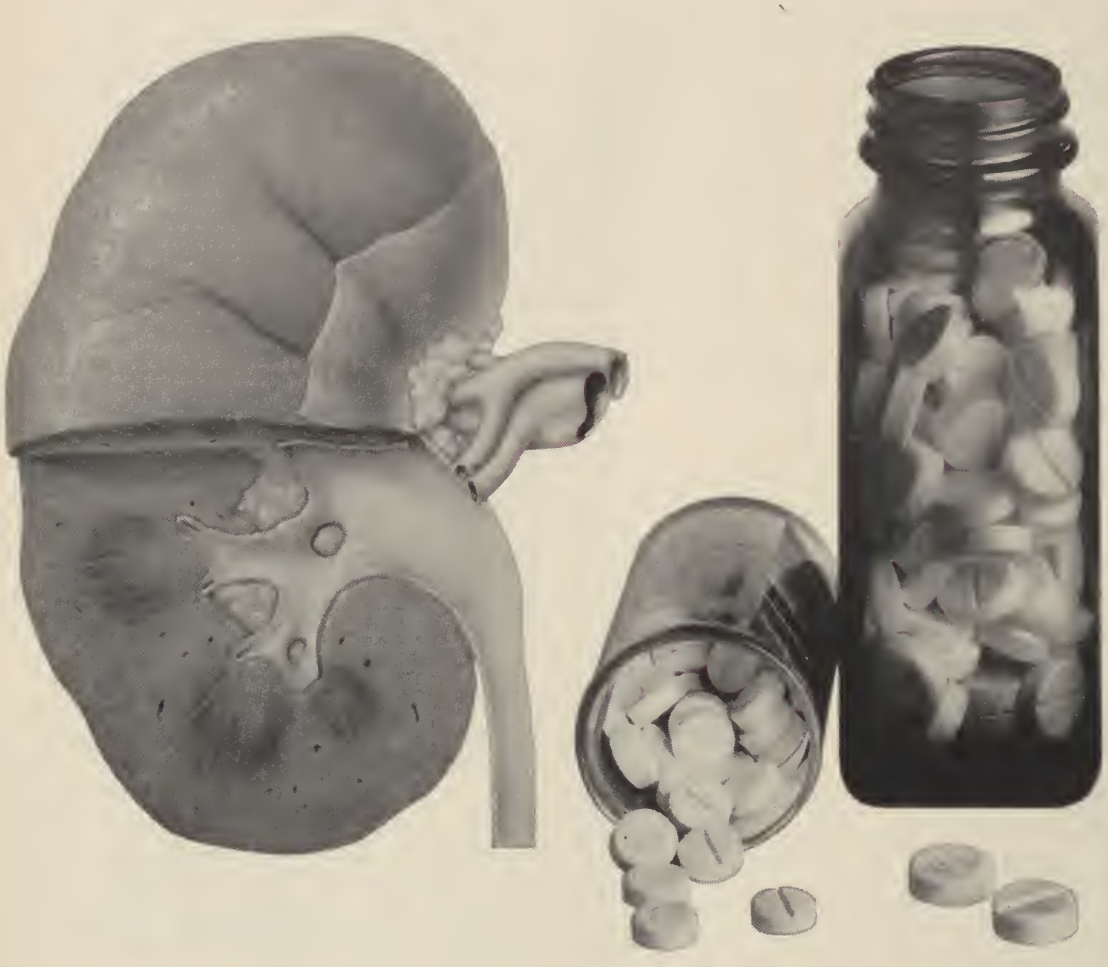
Fifth, and last, is the need for recognizing on a much larger scale the necessity for instituting within our medical schools and postgraduate training courses meaningful and fruitful teaching about overpopulation and its control. Surveys of the present extent of teaching in these subjects within the medical schools show a surprisingly indifferent approach to the subject by most of our schools.[8]

A recent report and recommendation of the Committee on Human Reproduction of the American Medical Association makes some pointed observations and some useful suggestions as to how the whole problem of fertility control can be better handled in our medical schools.[9] It deserves your close attention.

REFERENCES

1. Cook, R.C. (ed): *Population Bulletin* 20:30, 1964.
2. Wrong, D.H.: *Population*, New York: Random House, 1956.
3. Cook, R.C. (ed): *Population Bulletin* 16:90, 1960.
4. Doxiadis, C.A.: On the Measure of Man, *Proc Mayo Clin* 40:71, 1956.
5. *New York Times*, sect. C, p. 62, April 6, 1965.
6. Brown, L.R.: *Man, Land and Food*, Foreign Agricultural Economic Report No. 11, U.S. Dept. of Agriculture, 1963.
7. Lief, H.I., in Nash, E.M., Jessner, L., and Abse, D.W. *Marriage Counseling in Medical Practice*, Chapel Hill, N.C.: University of North Carolina Press, 1964.
8. Eliot, J.W.: *Teaching of Fertility Regulation in American Medical Schools: A Preliminary Report*, Seminar on Communication and Family Planning, University of Chicago, 1964.
9. Report of Committee on Human Reproduction of the American Medical Association, *JAMA* 191:31, 1965.

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The causes of the primary lung diseases in which respiratory failure occurs are briefly discussed. The principal types of respiratory failure are characterized with particular regard to the functional disturbances which can be favorably influenced by preventive and threapeutic measures. Treatment of both chronic and acute respiratory insufficiency is discussed.

Treatment of Respiratory Insufficiency

CARL MUSCHENHEIM, MD
Clinical Professor of Medicine, New York Hospital, Cornell Medical Center

THE PRINCIPAL LUNG DISORDERS which result in respiratory insufficiency and respiratory failure are the pulmonary fibroses, bronchitis, and emphysema. These disorders frequently coexist, but it is not accurate to consider them as separate components of a disease entity. They result from many and diverse causes, ranging from acute and chronic infections (among them, of course, tuberculosis) through known and unknown physical agents such as noxious dusts and gases, to processes of utterly obscure nature such as the so-called collagen disease, which may affect the lungs together with other organ systems, or affect the lungs alone in the form of nonspecific fibroses of the Hamman-Rich type and similar varieties.

Whereas bronchitis, emphysema, and fibrosis may be found in the end stages of many pulmonary diseases which culminate in respiratory failure, these anatomic conditions are not necessarily related to one another pathogenetically any more than they are etiologically. Moreover, each may progress in relatively pure form as the predominant defect to the stage of advanced functional respiratory insufficiency, pulmonary heart disease, and death from respiratory failure or congestive heart failure resulting from cor pulmonale. Thus, nonspecific interstitial fibrosis of the Hamman-Rich type has little in common, as regards the functional disturbance, with the more common types of so-called chronic lung disease, exemplified by bronchitis and emphysema and often designated collectively by the term *chronic obstructive lung disease*. The most widely held concept about the latter is that chronic bronchitis and emphysema are pathogenetically related, the bronchitis being the primary disorder and emphysema the consequence as well as the immediate cause of respiratory dysfunction.

Recent observations[1-3] indicate that chronic bronchitis and emphysema, while commonly associated, may each predominate to such an extent as to be sometimes virtually the independent cause of respiratory insufficiency. Instances of chronic bronchitis have been described which progressed to respiratory failure, pulmonary hypertension, and fatal cor pulmonale in which there was at postmortem examination no emphysema of anatomic importance.

Conversely, disabling emphysema may develop without antecedent or concomitant bronchitis; and bronchial obstruction, when it ensues, may then be due rather to airways collapse than to bronchitis. The term *chronic obstructive lung disease* thus

George M. Boyer, MD, Fund Lecture, presented April 22, 1965, before the Medical and Chirurgical Faculty of the State of Maryland.

leaves much to be desired, because it implies that bronchial obstruction is the cause of emphysema, whereas, contrariwise, it may be the consequence. Moreover, obstructive breathing is seen perhaps most characteristically in asthma, yet periodic asthma may go on for years without causing emphysema,[4,5] in the agreed pathologic sense of distention accompanied by *destructive* changes in the alveolar walls. Yet in status asthmaticus, as pointed out by Bates and Christie,[6] the functional state of the lungs is similar to that of advanced emphysema, and in such acute asthma carbon dioxide retention of severe degree may occur.

There are other kinds of anatomic derangements of the lungs than those already referred to, which may cause acute or chronic respiratory insufficiency and respiratory failure. To characterize them all would be beyond the purpose of this discussion. Including certain extrapulmonary restrictive conditions, some further causes of respiratory failure and of cor pulmonale are as follows: hydro- or pneumothorax, kyphoscoliosis, thoracoplasty, poliomyelitis, mucoviscidosis, diffuse infiltrations and granulomatoses such as sarcoidosis or beryllosis (which is not classed among the pneumoconioses), primary and secondary pulmonary malignancies, bronchiectasis, acute or chronic bronchiolitis, primary pulmonary hypoventilation in the obese and in the nonobese, recurrent multiple emboli, pulmonary arteriovenous fistulas, and finally the pulmonary dysfunctions related to primary cardiac disorders. The special problems of pulmonary dysfunction which occur in each cannot be elaborated here.

Various classifications of respiratory insufficiency have been formulated, and specific definitions of such terms as pulmonary insufficiency, ventilatory failure, and respiratory failure have been advanced to designate separate aspects of the problem. There appears to be no unanimity. A recent definition[7] which seems useful from the practical standpoint is of the term *respiratory failure* as the condition "when the tension of respiratory gases in the blood leaving the lungs is no longer within physiological limits." This may occur in the absence of intrinsic lung disease and may denote a failure of total ventilation, of effective alveolar ventilation, or of adequate gas transfer from any cause. If one accepts this definition, one can also include it under the broader term of respiratory insufficiency, in which the malfunction need not have progressed to the stage of disturbance of the blood gases but may nevertheless require therapeutic attention.

To return to the most common problems, namely those associated with pulmonary fibrosis, bronchitis, and emphysema, the physiologic derangements which can be modified by treatment fall into three main categories; namely, those related to exchange of gases between the lungs and the outside air, those related to exchange of gases between the alveoli in the lungs and the blood, and those related to the dynamics of the pulmonary circulation. Pulmonary heart disease and congestive failure secondary to pulmonary hypertension may become a complicating factor in respiratory insufficiency from any cause, but death from respiratory failure may occur without this complication. Disturbances of diffusion of gases across the alveolar capillary membrane may occur in a variety of conditions, including those in which obstructive ventilatory insufficiency is the predominant dysfunction; but it is the paramount disturbance in a special group of diffuse pulmonary fibroses with thickening of the alveolar-capillary membrane. As a prototype of the diseases in which such a diffusion defect predominates, one may consider a case of nonspecific interstitial fibrosis of the Hamman-Rich type (reported elsewhere in more detail).[8]

INTERSTITIAL PULMONARY FIBROSIS

Case Report

This man, when first seen at the age of 56, gave a history of increasing exertional dyspnea over the preceding 10 years. There was cyanosis on exertion. Marked finger clubbing was present. Many fine rales were present over the lower lung fields. The x-ray film showed diffuse fine linear and punctate infiltration in the lower lung fields and enlargement of the main branches of the pulmonary arteries bilaterally. The heart was not enlarged.

A biopsy of the lung was taken at an open operation, in which the lung was noted to be granular to palpation. The biopsy section showed extensive interstitial fibrosis, cuboidal metaplasia of the cells lining the alveolar spaces which remain, and other features similar to those described by Hamman and Rich. In this case the fibrosis was more mature, as the clinical history also was more chronic than in their original cases.

Function studies were made preoperatively, four

months postoperatively, and a year postoperatively. During the year the patient received a five-month course of prednisone therapy with no appreciable benefit. The vital capacity and maximum breathing capacity were not impaired. Minute ventilation was nearly twice normal at rest and with exercise, and recovery was poor after exercise. The arterial oxygen saturation at rest was normal in the first set of observations and was diminished only slightly at rest in the later observations. After exercise, however, the arterial oxygen saturation fell off sharply. These changes in ventilation and arterial oxygen saturation are characteristic of the syndrome of alveolar-capillary block. So also is the normal carbon dioxide tension in the arterial blood at rest, with slight decrease after exercise. The absence of CO_2 retention is, of course, in contrast to the situation in respiratory insufficiency associated with bronchitis and emphysema, in which hypercapnia and respiratory acidosis are constant threats.

Little could be done either to affect the underlying condition or to prevent the inexorable progress of the pulmonary hypertension and pulmonary heart disease. Polycythemia, which originally was not present, developed over the course of several years to the extent of red blood cell volumes in the range of 57-58%. Correction of the hematocrit, to a level of about 50, by means of small phlebotomies performed at irregular intervals failed to ward off eventually several episodes of congestive failure. These at first responded satisfactorily to digitalization and diuretics, but eventually they became refractory. The patient finally died of the pulmonary heart disease and probably complicating arteriosclerotic heart disease without any marked progression of the underlying pulmonary fibrosis up to within a few weeks of the terminal cardiac episode.

Comment.—This case history brings into focus the differences between the therapeutic problems in such instances in which the predominant functional defect is in diffusion and the problems in bronchitis and emphysema in which alveolar ventilation and distribution of gases are more at fault, and in which CO_2 retention as well as arterial hypoxia is encountered. The hypoxia in the respiratory failure of interstitial fibrosis, even when this becomes advanced and complicated by some degree of ventilatory insufficiency, usually can be relieved by oxygen therapy without much danger of precipitating respiratory acidosis. In the predominantly ventilatory deficiency of bronchitis and emphysema there exists, in contrast, usually an important degree of CO_2 retention which may be greatly aggravated by injudicious oxygen administration. Once congestive heart failure supervenes, it often becomes difficult or impossible to determine which set of pulmonary dysfunctions may underlie the pulmonary heart disease without recourse to frequent blood gas determinations; or even whether or not the heart failure is due to cor pulmonale rather than to some form of primary heart disease.

CHRONIC BRONCHITIS AND EMPHYSEMA

The therapeutic management of bronchitis and emphysema can best be discussed from two different points of view. The one is the ambulatory phase, in which the aim is not so much to restore damaged tissue or impaired function, although to some extent function can be improved, as it is to prevent further damage and to avert the often disastrous episodes of functional decompensation. Inasmuch as such episodes most often are precipitated by intercurrent infections, it is these particularly that must be prevented insofar as possible or, if they cannot be prevented, that must be cured as rapidly as possible.

Numerous studies have been made of various regimens of the so-called *prophylactic* antimicrobial therapy of chronic bronchitis. Some may wish to dispute the question of whether or not giving tetracycline or penicillin constantly, or intermittently on a regular schedule, is early treatment in contradistinction to true prophylaxis. Such arguments serve no important practical purpose in this particular connection, though it is perhaps important to bear the distinction in mind. The accumulated trials indicate, with few exceptions, that regular schedules of antimicrobial therapy do in fact limit disability and exacerbations. It seems not to matter a great deal whether the regimens are continuous or interrupted. Even administering therapy only for indications of incipient exacerbations may suffice, but it must be remembered that infection without the usual manifest signs, such as fever, may be enough to precipitate respiratory failure. Indications merely of increased cough or slight worsening of exertional dyspnea may be all there is to signify impending exacerbations, which often may be prevented by timely institution of antibiotic ther-

apy. This, of course, is not the only measure of prevention, but it seems quite obvious that a major reason for the increasing prevalence of so-called chronic lung disease is the availability and widespread use of antibiotics. In earlier periods infection carried most of these people off before they lived long enough to be chronically handicapped or incapacitated.

The interdiction of smoking, particularly cigarette smoking, is also urgent. Smoking more probably is a contributory rather than a primary cause of obstructive lung disease, but there is little doubt that it is an important aggravating factor. Less well recognized, but I am sure of considerable importance also, is alcohol. The fiction that alcohol is good for the heart and circulation is contradicted by every day clinical observations. It is contradicted also by recently published studies of Webb and Degerli.[9] This is not to express a bias against either tobacco or alcohol in moderation, but in any but modest amounts both are injurious to the heart and circulation and to the lungs, and particularly in causing or aggravating bronchitis.

As for improving function, various forms of exercise are the most important. Patients should be encouraged to exercise within their limits of tolerance. The value of exercising with oxygen has been demonstrated particularly by Barach[10] and confirmed by others. This is probably necessary only for those patients who are most severely handicapped, or during the rehabilitation phase after a break in compensation. Various forms of breathing exercises also have their place, even though it may be difficult to demonstrate benefit objectively by any of the usual measurements of lung function.

The bronchodilator aerosols may be useful, but these should be used somewhat sparingly because of their vasopressor and cardiac stimulating effect. Moreover, unless it is shown that they produce an increment of more than 10% in vital capacity and maximum breathing capacity, it is doubtful that they are of any value. It has not been shown that these agents are any more effective when given as aerosols with intermittent positive pressure breathing devices (IPPB) than by a simple hand nebulizer or a motor blower.

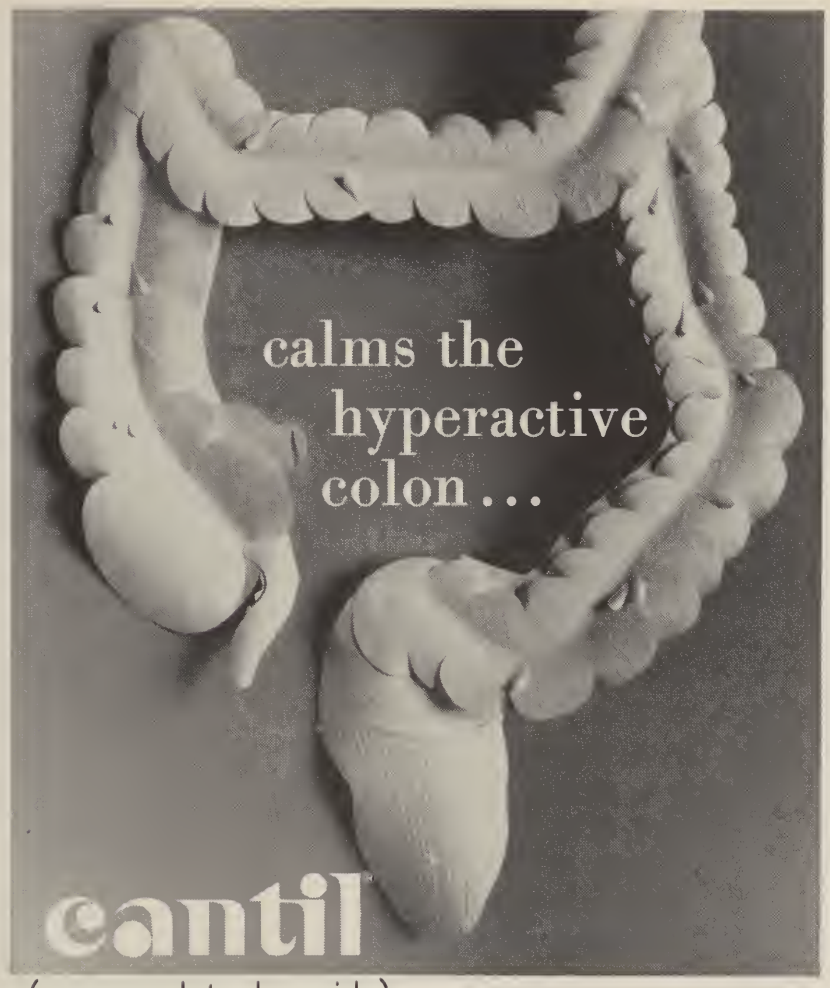
Patients who have very viscid and tenacious secretions may benefit from either potassium iodide in saturated solution or from the newer mucolytic agents. Most ambulatory patients receiving adequate antibiotic therapy do not need these agents. There seems to be little advantage either in respiratory stimulants, such as Ethamivan, in this phase of treatment.

Carbonic anhydrase inhibitors are of value principally as diuretics in patients who are in borderline cardiac compensation. These patients should, of course, also be digitalized. Beyond these measures which have been mentioned there is little to do for the ambulatory patients except for giving them a large measure of reassurance. This is more important in most instances than surrounding them with apparatus. Many are impatient with their handicap, even when it is not severe and need not limit them too harshly in useful activities. Others are frightened by what they read and hear about emphysema, which in recent years has been extensively but not too accurately publicized. Most often, if told they have "some" bronchitis and "not too much" emphysema, and that the latter need not be progressive, their apprehensions will be greatly relieved.

ACUTE RESPIRATORY FAILURE

Acute respiratory failure requires prompt hospitalization and corrective measures. There is no unanimity, however, about the best way to manage these emergencies; indeed, the recent literature on the subject is both voluminous and contradictory. Positive claims are made favoring one method or another, but few authors report their total experience, or their total experience is not large, or it is not comparable with that of others. This is not to say that there has not been a great deal of careful work reported. Indeed, there has been, and there is emerging agreement at least on the fundamental elements of successful treatment. It is only with the relatively recent availability of quick and accurate methods of blood gas analysis that adequate monitoring of the course of events has been possible in any but the most elaborately equipped research centers. Disagreements persist about the indications for such aggressive procedures as tracheostomy, about the indications for and the proper ways of administering oxygen, about the indications for mechanical aids to ventilation, and about the best methods of administering artificial ventilation.

Gradually there has been a recognition that, far from being contraindicated, oxygen adminis-



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helps restore normal motility and tone

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with little effect on stomach, bladder or other viscera.

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IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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tration is essential in acute pulmonary insufficiency with respiratory acidosis, which usually is associated with a severe degree of hypoxia. There is, of course, a delicate balance between the benefit to be derived from oxygen administration and its potential danger of depressing ventilation by diminishing the hypoxic drive to ventilation. In a patient who is hypoventilating and retaining carbon dioxide, the administration of oxygen in high concentration may remove this drive altogether and precipitate respiratory acidosis and carbon dioxide narcosis. The appreciation of this danger resulted for some time in excessive caution among many physicians and a policy of withholding oxygen altogether. This trend sometimes went so far even as to the withholding of oxygen in patients with cor pulmonale secondary to interstitial fibrosis with the alveolar-capillary block syndrome, in which situation carbon dioxide retention is not a factor. In the pulmonary insufficiency of obstructive lung disease, however, respiratory acidosis is always a potential hazard and oxygen, though usually indicated, must be given with care.

Barach,[10] in this country, and Campbell,[11] in England, have advocated regulated low flow continuous oxygen, increasing the flow rate and the concentration very slowly and by small increments. Moderate elevation of arterial blood carbon dioxide tension is not considered a danger by these workers, provided that the pH of the blood is not in the acidotic range. Miller,[12] of Parkland Memorial Hospital, Dallas, also has maintained that the danger of using oxygen in patients with chronic obstructive lung disease with long-standing hypoxia and CO_2 retention has been exaggerated. He recommends 30-40% concentrations of oxygen as adequate for correction of oxygen lack from hypoventilation. If depression of ventilation ensues, as indicated by increasing pCO_2 and falling pH, then either mechanical ventilatory assistance or stimulation of respiration by such an agent as ethamivan is recommended. Others, however, have reported unfavorably on ethamivan for this purpose.

The carbonic anhydrase inhibitor, dichlorphenamide, has been favorably reported by some for the same purpose. Others have objected that since it produces respiratory stimulation by inducing metabolic acidosis, it cannot be employed without danger.

Aminophylline, intravenously, has been favorably reported in a careful study of two patients, as counteracting the respiratory depression resulting from oxygen. Still others have attempted the use of a carbon dioxide buffer, trishydroxymethylaminomethane (TRIS, THAM), to directly correct the acidemia. This it does, but it also directly depresses respiration and aggravates hypoxia. It is for this reason dangerous and is recommended by few, and then only under conditions of absolute control of ventilation. Neither have the direct and indirect respiratory stimulants become widely accepted or used. Mechanical aids to ventilation, in contrast, are widely employed.

I will not go into the details of the various kinds of respirators and ventilatory assistors which are so widely employed for both good and less good indications. The Bennett and Bird apparatuses, among the assistors, and the Drinker tank respirator are the most familiar. The difficulties attendant on prolonged administration of artificial or assisted ventilation have resulted in the development of intensive respiratory care units in many hospitals. This trend is continuing and it seems increasingly to be necessary. For the patient in coma or precoma from acute respiratory failure, tracheostomy and mechanical assistance, either by an IPPB device connected to a cuffed tracheostomy or by tank respirator, is usually necessary.

Bates,[13] of Montreal, who established an efficient intensive care unit at the Royal Victoria Hospital some years ago, prefers the former method to the tank respirator. He insists on tracheostomies being performed in the operating room and always after preliminary tracheal intubation. Frequent monitoring of the arterial blood gases and pH is essential. Bates rarely resorts to tracheostomy unless the pCO_2 is 70 mm Hg or more. The average pCO_2 at the start of respirator care in his series of emphysema patients was 85 mm Hg. These were, therefore, severely ill patients. Eleven of 22 patients survived for two years or more after treatment of the acute episode.

Lyons,[14] of Downstate Medical Center of New York, considers tracheostomy and sustained IPPB to be indicated whenever the arterial pCO_2 is 65 mm Hg or more. Feldman and Williams[15] of Albert Einstein Medical College, in contrast, who recently reported on the results of treatment in the only large consecutive series of ventilatory



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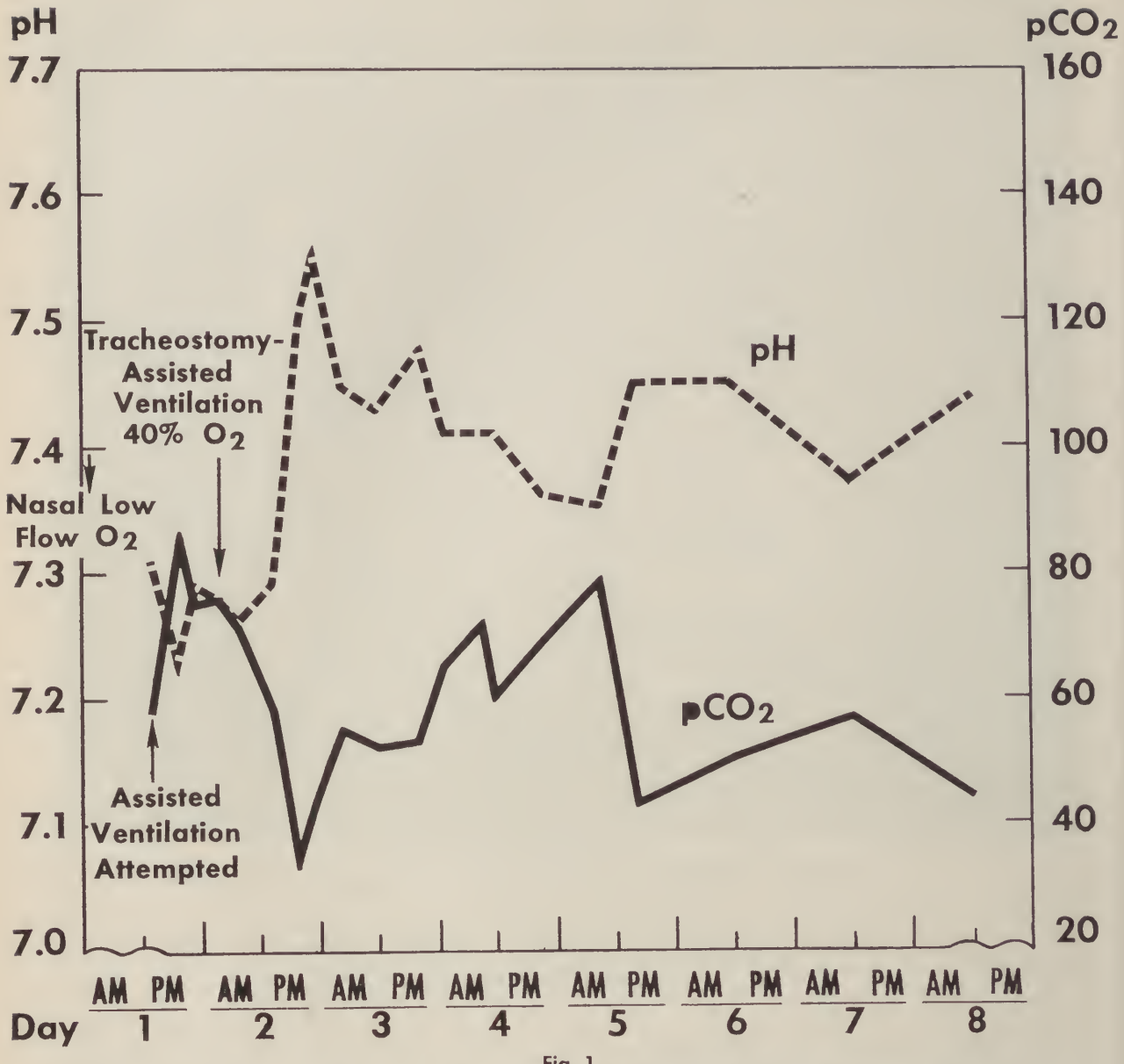


Fig 1

Course of pCO_2 and pH of arterial blood during treatment of respiratory failure. Man, age 54. Chronic bronchitis and emphysema with intercurrent pneumonia.

failure patients so far published, were more conservative. In 109 admissions of 83 patients they performed tracheostomies only 16 times, although more than half their patients had arterial pCO_2 of 60 mm or more on admission. Their mortality, incidentally, in this series was 18%. The series comprised all patients admitted in an 18-month period whose admission pCO_2 was 50 mm or more.

The experience at New York Hospital has not been inclusively studied, and establishment of a respiratory intensive care unit is still in the planning stage. The data relative to several cases recently treated on the general medical wards, but closely monitored with blood gas and arterial blood pH determinations, may illustrate some therapeutic problems of respiratory failure which are commonly encountered and for which the means now are available for more effective management than was formerly practicable.

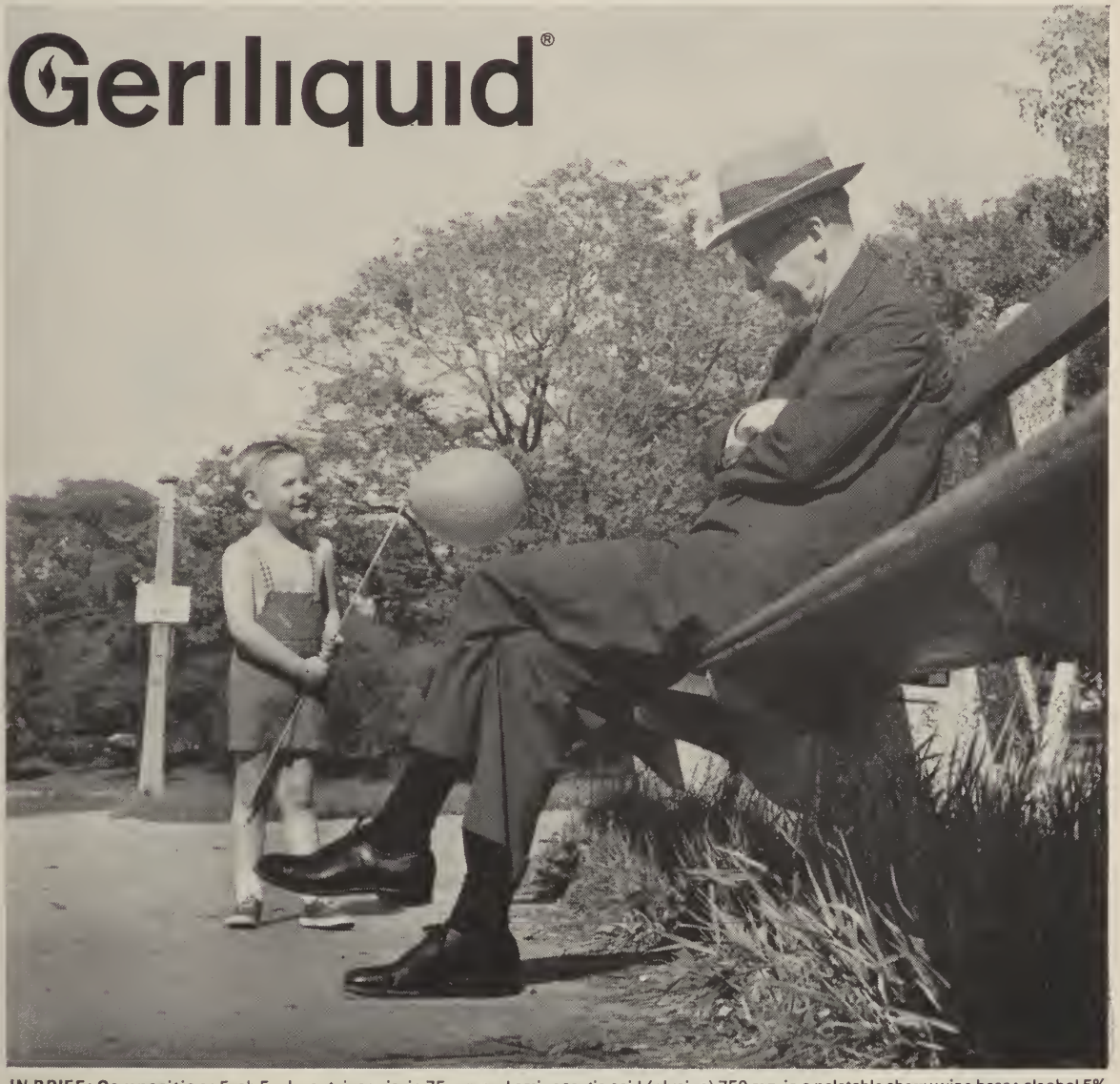
The values are charted in Fig 1 of arterial pCO_2 and pH over an eight-day period in the

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case of a 54-year-old man with chronic bronchitis and emphysema and a complicating bronchopneumonia. Each graph represents a total of 20 determinations, those of pCO_2 being depicted by the solid line and those of pH by the broken line. (The observations were not even'y distributed and became less frequent as the patient's condition improved.) Several determinations were made also of pO_2, but these are omitted from the chart for simplicity and because hypoxia, though present, was not extreme. Low flow oxygen administration by nasal cannula was initiated immediately upon admission and before the first determinations were made. These showed a moderately severe respiratory acidosis with arterial pCO_2 58 mm Hg and pH 7.31. Assisted ventilation with IPPB by mask was attempted, but the procedure could not be regulated satisfactorily, so that the CO_2 retention and acidosis became worse. The pCO_2 and pH reached the dangerous levels of 86 and 7.22, respectively. Attempted adjustment of the ventilatory assistance brought only slight improvement, which was maintained precariously during the first night, with the pCO_2 hovering at 75 to 76 mm and the pH between 7.26 and 7.29.

Early on the second day a tracheostomy was performed and ventilatory assistance by IPPB was given through a cuffed tracheostomy tube. Forty per cent oxygen was used. It is evident that a considerable degree of overventilation ensued, and the pH attained a peak of 7.56, representing a reversal from respiratory acidosis to respiratory alkalosis. This can be dangerous and may induce a hypokalemia,[16, 17] especially if potassium stores are already depleted by prior administration of diuretics.

Over the third and fourth days the alkalosis was corrected, but the pCO_2 again rose to as high as 79 mm on the fifth day. At this time, however, there was no corresponding fall in pH to acidotic levels, presumably because of renal compensation. The lowest pH value was 7.35, which is the lower limit of normal. Readjustment of the ventilatory assistance and the patient's general improvement now resulted in a more stabile correction of the CO_2 retention. Both the pCO_2 and pH remained in the normal or near normal range on the sixth, seventh and eighth days, during which ventilatory assistance could gradually be withdrawn.

The next instance (Fig 2) is of respiratory failure in a 57-year-old woman with severe obstructive airway disease and cor pulmonale of long standing. Severe respiratory acidosis was present on admission, with pCO_2 99 mm and pH 7.27. Coma may be present with hypercapnia of this degree, but this patient was conscious and able to cooperate in receiving assisted ventilation by mask. Compressed aid was used initially because of concern about the use of oxygen in a patient already in severe acidosis. There was initial improvement, but this was not sustained. More rapid later correction of the acidosis coincided with the substitution of oxygen for air, and the improvement now was sustained. (The chart, perhaps, is misleading in connecting by straight lines the last observations on day 3 with observations on day 8. No blood gas or pH determinations were made on the fourth to seventh days, inasmuch as the patient was clinically improved and clearly out of danger.)

Comment.—The main interest in this case is in the recovery from severe respiratory failure without tracheostomy. A secondary point of interest is that the withholding of oxygen was unnecessary. It may even have delayed recovery beyond what might have been achieved had 40% oxygen been used in the first place, since hypoxia itself may indirectly aggravate respiratory acidosis.

The final set of data (Fig 3) concern a healthy middle-aged man who contracted measles and who was sufficiently dyspneic from an associated bronchiolitis to have been given oxygen by nasal catheter. When this was started there was moderate hypercapnia with pCO_2 50 mm. There was also moderately severe acidosis, and the pH stood at 7.27. The patient was cyanotic, and rales were widespread, but the chest x-ray showed no abnormal shadows. After three hours the pCO_2 had risen to 70 mm and the pH had declined to 7.23, thus falling below 7.25, which by some authorities is regarded as the danger level in respiratory acidosis. Despite assisted ventilation with an IPPB device, administered initially by tracheal intubation and later by tracheostomy, the patient's condition rapidly deteriorated and coma supervened. When the blood pCO_2 reached the peak of 150 mm and the pH had fallen to 7.10, the patient was placed in a tank respirator. After six hours consciousness returned, and within 10 hours the respiratory acidosis was largely corrected. The patient was removed from the

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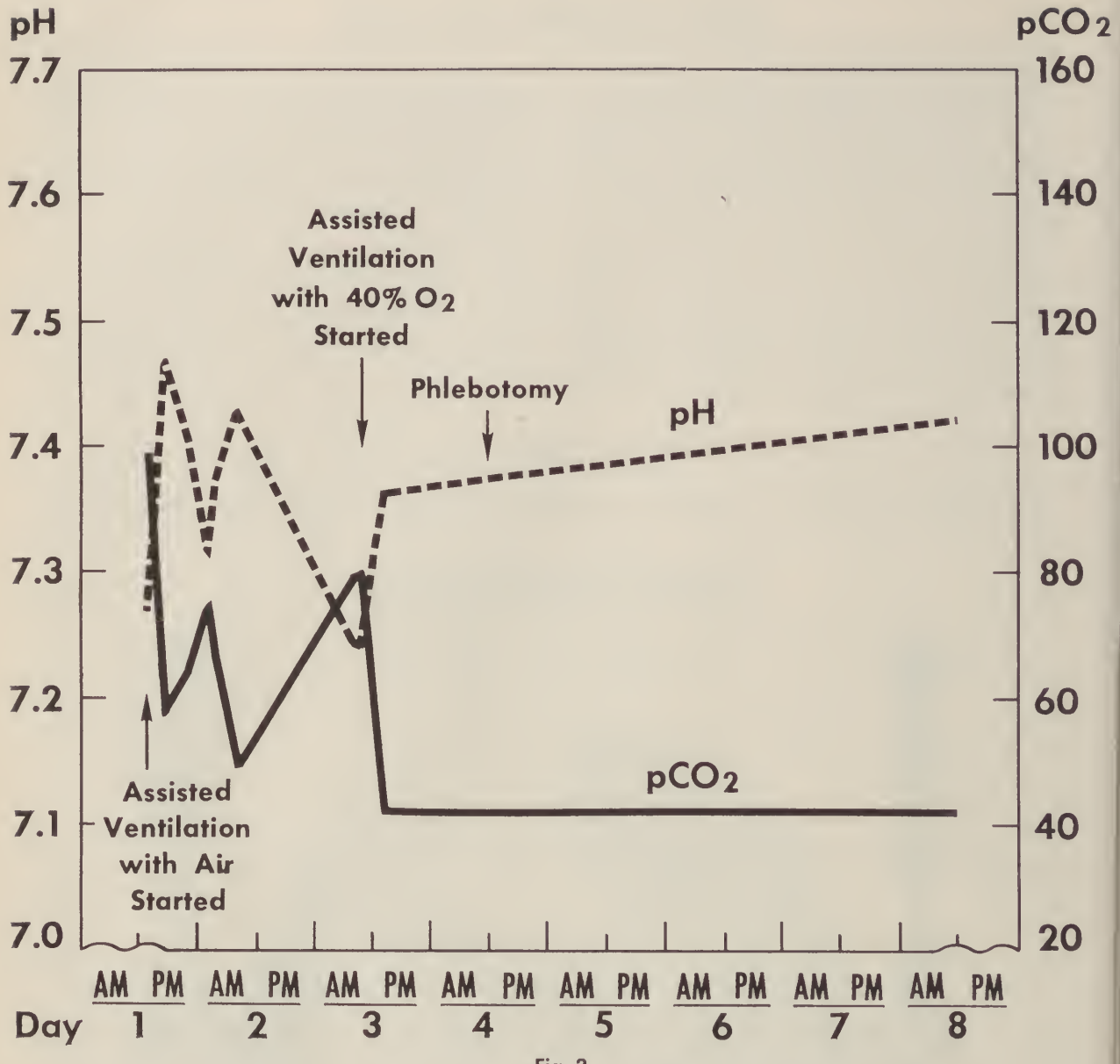


Fig 2

Course of pCO_2 and pH of arterial blood in treatment of respiratory failure. Woman, age 57. Obstructive airway disease and cor pulmonale.

respirator within 24 hours and the recovery thereafter was uneventful.

Comment.—The interpretation of this course of events is difficult. Campbell[18] has stated that pCO_2 elevation of this degree does not occur unless respiration is depressed by drugs or by the incorrect use of oxygen. In connection with the latter, he has pointed out that the nasal catheter is an uncertain means of delivering oxygen in low concentration. For controlled low flow oxygen administration he has developed a special mask using the venturi principle. In the present instance, nasal oxygen was administered for only a short time, and the deepening of respiratory acidosis continued precipitously despite assisted venti'ation by usually effective means. The patient, moreover, had not received sedative medications. It seems probable, therefore, that it was the fulminating character of the disease that precipitated the extreme respiratory failure rather than any therapeutic mismanagement. Undetected mechanical faults, nevertheless, are a constant



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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

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SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

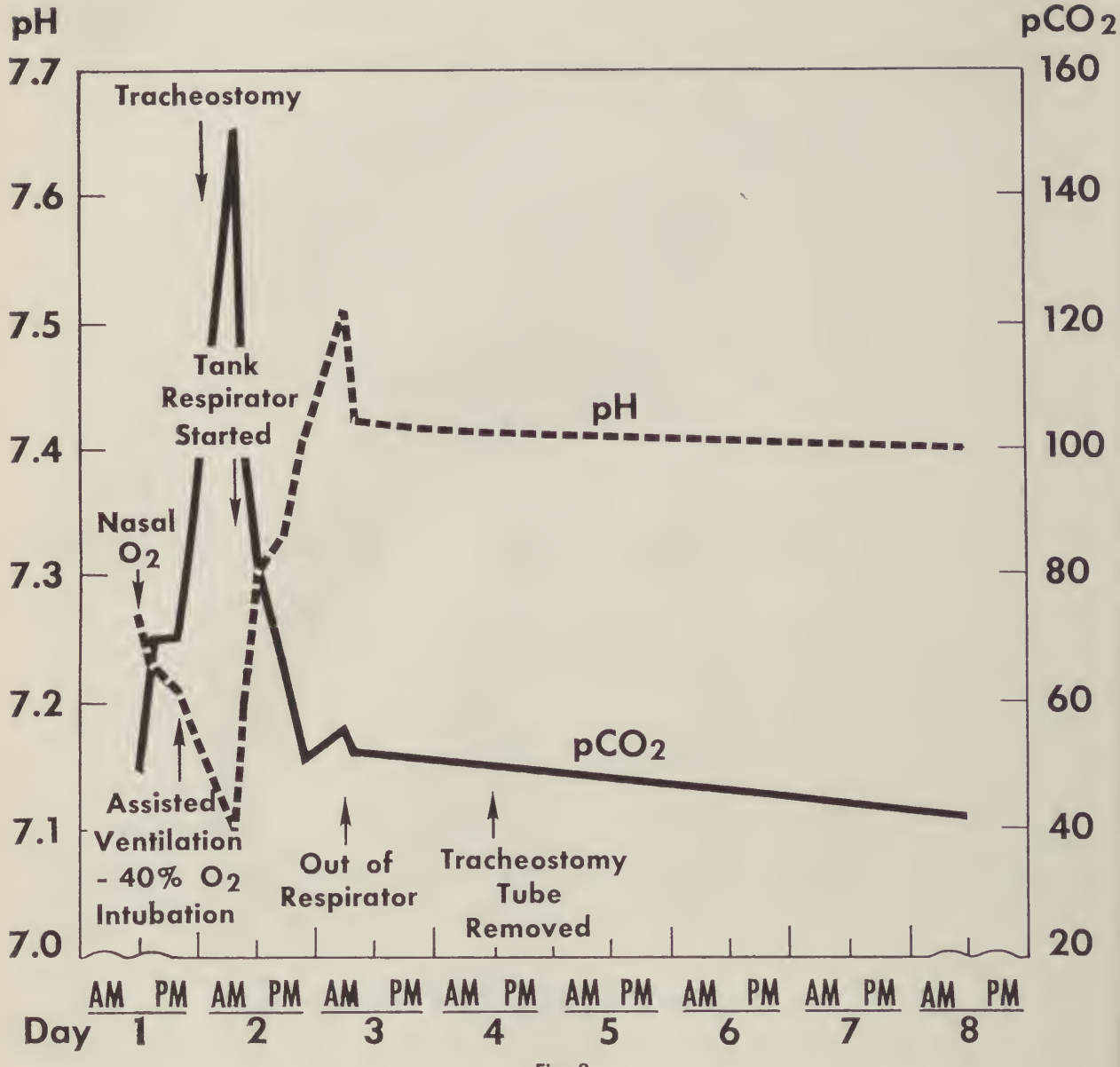


Fig 3

Course of pCO_2 and pH of arterial blood in treatment of respiratory failure. Man, age 53. Measles bronchiolitis.

and considerable hazard whenever long-term assisted ventilation is undertaken, and such cannot be conclusively ruled out as a contributory factor in the present instance. The close monitoring of arterial blood pCO_2 and pH, however, permitted an immediate recognition of the cause of the coma and the prompt resort to an alternate means of correcting a situation which rapidly was becoming disastrous.

In conclusion, the best treatment of respiratory failure is the timely recognition of respiratory insufficiency and in the prevention of factors which may precipitate failure. Once respiratory decompensation has progressed to the stage of severe alterations in the tension of oxygen and carbon dioxide in the blood, and the buffer system comes under sufficient stress to permit acidosis to develop, a serous medical emergency is at hand. The availability of rapid and reliable means of determining arterial blood pH, pCO_2, and pO_2, or oxygen saturation, does not reduce the complexities of therapy in such an emergency, but it does

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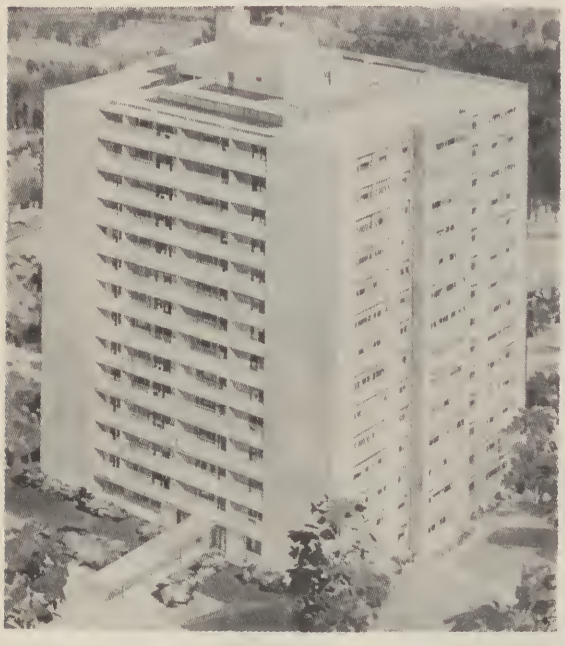
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provide a means of guiding treatment procedures so that these may be effectively applied in most instances.

Special training in the management of mechanical aids to ventilation is essential if these are to be used effectively. Appreciation of the hazards of aggressive measures, including the complications of tracheostomy, which too often is regarded as entirely an innocuous procedure, need not lead to an attitude of over-conservatism but rather to a desirable individualization of treatment. Not until a larger number of results are known in statistically significant series of comparable cases will it be clear what are the optimal treatments for successively severe stages of respiratory failure.

133 East 64th St.
New York, N.Y 10021

REFERENCES

1. Wright, G.W., and Kleinerman, J.: Consideration of Etiology of Emphysema in Terms of Contemporary Knowledge: J. Burns Amberson Lecture. *Amer Rev Resp Dis* 88:605, 1963.
2. Hentel, W., et al: Fatal Chronic Bronchitis. *Amer Rev Resp Dis* 87:216, 1963.
3. Fletcher, C.M., et al: Diagnosis of Pulmonary Emphysema in Presence of Chronic Bronchitis. *Quart J Med* 32:33, 1963.
4. Symposium on Emphysema and Chronic Bronchitis Syndrome, 1958. *Amer Rev Resp Dis* 80:1, 1959.
5. Gough, J.: Correlation of Radiological and Pathological Changes in Some Diseases of the Lung. *Lancet* 1:161, 1955.
6. Bates, D.V., and Christie, R.V.: Respiratory Function in Disease. Philadelphia: W.B. Saunders, 1964, p. 149.
7. Ibid, p. 445.
8. Muschenheim, C.: Some Observations on the Hamman-Rich Disease. *Amer J Med Sci* 241:279, 1961.
9. Webb, W.R., and Degerli, I.U.: Ethyl Alcohol and the Cardiovascular System. *JAMA* 13:1055, 1965.
10. Barach, A.L.: Inhalation Therapy, Advances and Retreats. *Anesthesiology* 22:367, 1961.
11. Campbell, E.J.M.: Oxygen Therapy in Diseases of the Chest. *Brit J Dis Chest* 58:149, 1964.
12. Miller, W.F.: Oxygen Therapy: Catheter, Mask, Hood and Tent. *Anesthesiology* 23:445, 1962.
13. Bates, D.V., and Christie, R.V.: op cit, p. 470.
14. Lyons, H.A.; Becker, W.H.; and Torres, G.E.: Management of Severe Pulmonary Emphysema. *Amer J Med* 36:62, 1964.
15. Feldman, R., and Williams, M.H., Jr.: Acute Ventilatory Failure. *New York J Med* 63:3355, 1963.
16. Refsum, H.E.: Hypokalemic Alkalosis during Recovery from Compensated Respiratory Acidosis. *Scand J Clin Lab Invest* 14:545, 1962.
17. Robin, E.D.: Abnormalities of Acid-Base Regulation in Chronic Pulmonary Disease, with Special Reference to Hypercapnia and Extracellular Alkalosis. *New England J Med* 268:917, 1963.
18. Campbell, E.J.M.: op cit.

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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. 8:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

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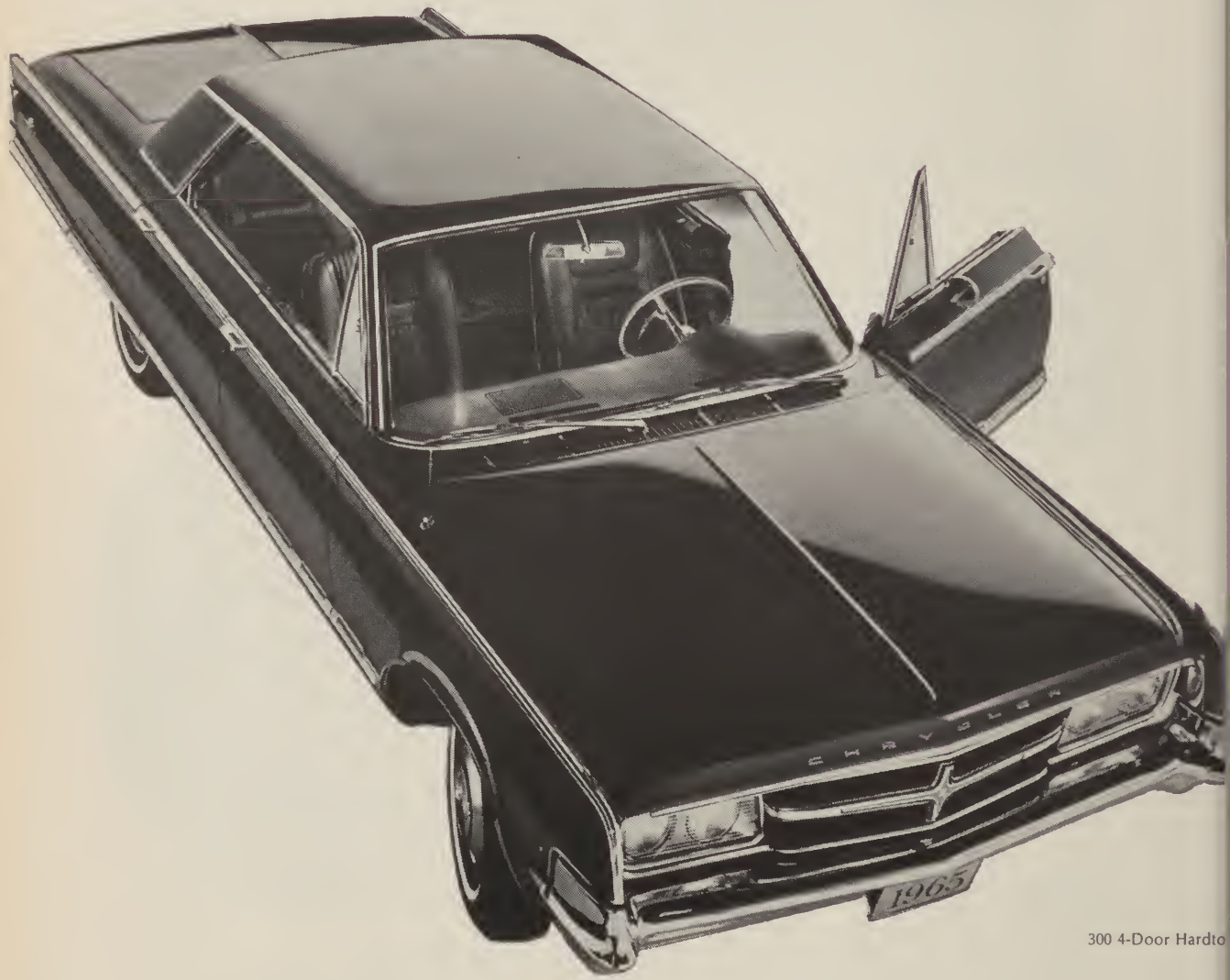
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BUSINESS SESSIONS

SEMIANNUAL MEETING
September 11, 1964

MINUTES

The 247th meeting, Semiannual Session, of the House of Delegates of the Medical and Chirurgical Faculty of Maryland, was called to order at 9:40 AM, Friday, September 11, 1964, at Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. An asterisk indicates an alternate delegate.

Doctors: *A. A. Alecce, Baltimore City; John G. Ball, Montgomery County; Richard D. Bauer, Council; Harry M. Beck, Baltimore City; D. W. Benson, Baltimore City; M. McK. Boyer, Council; P. Briscoe, Anne Arundel County; F. E. Brumback, Washington County; R. vL. Campbell, Council; Henry V. Chase, Council; *J. N. Cianos, Baltimore City; *D. S. Clayman, Prince George's County; E. P. Coffay, Baltimore City; A. R. Cohen, Washington County; E. I. Cornbrooks, Baltimore City; Merrill Cross, Montgomery County; Everett S. Diggs, Council; L. C. Dobihal, Baltimore City; J. Sheldon Eastland, Council; W. C. Ebeling, Council; J. McC. Finney, Harford County; S. Goldgraben, Cecil County; A. E. Goldstein, Council; Edward G. Grau, Baltimore County; P. F. Guerin, Baltimore City; J. R. Guyther, Council; W. B. Hagan, Prince George's County; Thurston Harrison, Council; F. J. Heldrich, Frederick County; P. W. Heuman, Harford County; James P. Jarboe, St. Mary's County; F. M. Johnson, Charles County; W. T. Joyce, Montgomery County; J. R. Karns, Baltimore City; Fayne A. Kayser, Council; L. L. Keown, Baltimore City; H. F. Kinnamon, Past President; Amos R. Koontz, Council; H. P. Laughlin, Council; *L. Levitsky, Prince George's County; *C. B. Marek, Baltimore City; H. B. Mays, Council; Karl F. Mech, Council; B. M. Middleton, Baltimore City; *D. W. Mintzer, Baltimore City; J. E. Miller, Baltimore City; *M. I. Mones, Montgomery County; W. C. Morgan, Wicomico County; *H. T. Morse, Montgomery County; G. A. Moulton, Carroll County; J. E. Muse, Jr., Baltimore City; C. F. O'Donnell, Council; A. A. Pearre, Past President; W. A. Pillsbury, Council; J. Emmett Queen, Council; J. R. Rappeport, Baltimore County; B. R. Reap, Montgomery County; J. M. Reese, Council; Guy M. Reeser, Talbot County; E. J. Riley, Baltimore City; R. C. Robinson, Baltimore City; A. B. Rohrbaugh, Council; Donald Roop, Council; Edwin Ruzicka, Talbot County; *P. A. Santucci, Montgomery County; E. Schimunek, Baltimore City; *W. B. Settle, Baltimore City; R. A. Sindler, Baltimore City; Aaron C. Sollod, Baltimore City; O. D. Sprecher, Washington County; M. E. Strobel, Baltimore County; E. Suarez-Murias, Baltimore City; *W. J. Sullivan, Baltimore City; R. S. Turner, Frederick County; H. R. Trapnell, Caroline County; L. A. Wall, Baltimore City; Hugh W. Ward, Calvert County; J. Arthur Weinberg, Council; C. H. Williams, Baltimore County; Hans Wodak, Prince George's County; E. H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; Arthur O. Wooddy, Council; John D. Young, Baltimore City; Mr. Walter N. Kirkman.

Present also for the meeting were staff personnel.

The President made certain announcements with regard to the conduct of business at the session.

MINUTES

The minutes of the May 6 and 8 meetings, respectively, of the House of Delegates, annual session, having been distributed to the members, were amended by changing the meeting number to read "166th" in the first paragraph.

EMERITUS MEMBERSHIP

On recommendation of the Council, the following member was elected to Emeritus Membership: George S. Weber, MD, retired, Charles County.

FACULTY DELEGATES TO AMA REPORT

The report of the Faculty's Delegates to the American Medical Association was filed.

BYLAWS COMMITTEE REPORT

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, reported to the House of Delegates recommending that the following Bylaw amendment, which had been recommitted to it by the previous session, not be adopted. The amendment was rejected.

> "Amend Article XI, Section 3, by inserting after 'expense' the words, 'in the State of Maryland.'"

MEDICOLEGAL COMMITTEE REPORT

Dr. Kinnamon, on behalf of the Medicolegal Committee, recommended adoption of a proposed Medicolegal Code of Cooperation which had previously been adopted by the Maryland Bar Association and the Bar Association of Baltimore City. The House of Delegates adopted the Code.

REPORT OF THE FACULTY'S REPRESENTATIVE TO BLUE SHIELD

Dr. Davidson presented the report of the Faculty's

Representatives to Blue Shield and moved on behalf of the representatives that the following resolution be adopted:

> *Resolved,* That the Faculty Representatives to the Blue Shield Board of Trustees are authorized at this time to discontinue their efforts in connection with the transfer of radiology, pathology, and so forth, from Blue Cross to Blue Shield.

By more than a two-thirds vote this recommendation was adopted.

PROFESSIONAL FEE FUND COMMITTEE REPORT

Dr. Settle, on behalf of the members of the Professional Fee Fund Committee, reported to the House of Delegates and, on behalf of the Committee, moved the adoption of the following resolutions:

> *Resolved,* That in the light of the decision of the Court of Appeals of Maryland, as reported in the *Daily Record,* March 24, 1964, regarding the corporate practice of funeral directors, immediate steps should be taken to ascertain the legality of corporate practice of medicine in Maryland, by court action if necessary.

> *Resolved,* That all physicians in Maryland who are members of the Faculty be advised that in regard to the corporate practice of medicine, they must comply with the Principles of Medical Ethics as established by the American Medical Association, and that failing to do so will result in charges being brought against them for unethical conduct through the mechanisms provided in the Faculty Bylaws and the Medical Practice Act of Maryland.

After debate and motions to divide the resolutions for separate vote and to postpone action on the resolutions were both defeated, the House adopted the resolutions as submitted by the Committee.

NO REFERENCE COMMITTEE REPORT

The President announced that there was no Reference Committee report inasmuch as no resolutions had been submitted by the deadline established in the Bylaws.

MOMENT OF SILENCE FOR LATE AMA PRESIDENT

The House of Delegates observed a moment of silence for Norman A. Welch, MD, President of the American Medical Association, who died suddenly while serving in this capacity.

PRESENTATION OF BOOK IN MEMORY OF HARRY J. FRIEDENWALD, MD

The President then made a presentation* of an original book written by Florence Nightingale, *Notes on Nursing.* This book, for the Faculty library's rare book collection, was donated by Mrs. Julia Potts, a nurse of Dr. Friedenwald.

The House then rose in memory of Dr. Friedenwald.

LEGISLATIVE ACTION

Dr. Middleton, Legislative Committee Chairman, addressed the House and asked that the House continue its opposition to the Gore-Anderson amendment to the Social Security bill which had been adopted by the U. S. Senate; to make known this by despatch of telegrams to elected Congressmen from Maryland and others; and asked each and every physician in the room to reaffirm his dedication to the principles of the private practice of medicine.

On vote, the above recommendations were adopted unanimously.

The President then made several announcements.

Whereupon, by unanimous consent, the House adjourned *sine die* at 11:20 AM.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, *Secretary*

*See *Maryland State Medical Journal* 13:44 (Nov.) 1964.

REPORTS

To The House of Delegates

All recommendations and resolutions in ***bold type.***

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

The Bylaws Committee met on June 11, 1964, to consider the question referred to it by the House of Delegates on May 6, 1964. This dealt with the proposed amendment to the Bylaws as follows:

(CAPS portion to be added)

Article XI Section 3. The Faculty shall assume payment of counsel fees for professional services rendered and the attorney's travel expenses IN THE STATE OF MARYLAND, but all other charges or costs, including those for stenographic services, preparation and printing of record on appeal, expenses of the defendant or witnesses or damages or plaintiff's costs awarded by the court shall be borne by the defendant.

After due consideration, the committee agreed that to attempt to spell out the conditions under which the attorney's travel expenses would or would not be paid would be extremely difficult and hard to express. In addition, there might well be a deserving case in which the Council would not be permitted to use its discretion and, consequently, any such amendment might restrict unduly the Council's actions.

In view of this, the Bylaws Committee makes no recommendations for changes in the Bylaws and recommends that this particular section remain as it presently is.†

It was the feeling of the Bylaws Committee that the Council should be in the position of using its discretion in granting legal defense, inasmuch as legal defense is granted by the Council, individually, as it is requested.

Respectfully submitted,
CHARLES F. O'DONNELL, MD, Chairman
M. MCKENDREE BOYER, MD
EDMOND J. MCDONNELL, MD
WHITMER B. FIROR, MD

MARYLAND MEDICAL SERVICE, INC. BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

The Blue Shield Board has pursued its efforts to effect a transfer of radiology and pathology benefits from Blue Cross to Blue Shield. A survey made by the Hospital Cost Analysis Service indicated that the transfer

†Adopted, see minutes.

of inpatient services would be costly to subscribers, but a transfer of outpatient radiology benefits could effect some savings. The Blue Shield Board therefore recommended that outpatient radiology and pathology benefits be transferred to Blue Shield. A final request was made to the Blue Cross Board, on March 25, 1964, to relinquish this coverage, but was denied. It seems useless to pursue the matter any further with Blue Cross at this time.

Attached to this report are documents pertinent to our efforts to bring about such change in benefits (Appendix 1). Also attached is a report to the Maryland Radiological Society, with recommendations which were adopted, and remarks by John M. Dennis, MD, both dealing with improvement of radiologic practice (Appendix 2).

Respectfully submitted,
CHARLES N. DAVIDSON, MD
President

APPENDIX 1

MAY 25, 1964: COVERING LETTER TO DR. PILLSBURY FROM CHARLES N. DAVIDSON, MD, PRESIDENT, BLUE SHIELD:

William A. Pillsbury, MD
Secretary
Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore, Maryland 21201
Dear Doctor Pillsbury:

Enclosed is pertinent material on the recently completed cost survey and recommendations related to the proposed transfer of radiology and pathology benefits from Blue Cross to Blue Shield. As you will recall, the transfer of benefits was requested by the Medical and Chirurgical Faculty of Maryland.

From the standpoint of cost alone, it seemed inadvisable to request a transfer of inpatient radiology benefits at this time; however, we hoped to obtain a transfer of outpatient benefits with a definite saving in cost. The Blue Shield Board approved this transfer, but for it to be effective, subscriber benefits in Blue Cross had to be relinquished. In addition to the effort made at committee level with Blue Cross members to accomplish a recommendation for the outpatient transfer, another plea (see enclosure) was made to the Blue Cross Board at its meeting on March 25, 1964, when this matter was being considered. The Blue Cross Board turned down our request. The matter stands now as before, i.e., no change.

It is unfortunate that Blue Cross would not cooperate to the extent of at least granting the outpatient benefits. It seems useless to pursue the matter any further with Blue Cross at this time.

Sincerely yours,
CHARLES N. DAVIDSON, MD
President, Blue Shield

MARCH 25, 1964: REMARKS CONCERNING THE PROPOSED TRANSFER OF RADIOLOGY AND PATHOLOGY BENEFITS FROM BLUE CROSS TO BLUE SHIELD, BY CHARLES N. DAVIDSON, MD, AT THE MEETING OF THE BLUE CROSS BOARD OF TRUSTEES.

It was most disappointing to learn about the recent report of the Blue Cross Subscriber's Benefit Committee, and its recommendations not to transfer benefits for outpatient department radiology and pathology from Blue Cross to Blue Shield.

I do want to thank Mr. Bamberger, president of this board, for the opportunity to appear here today to present to you the reasons why there should be a transfer of the outpatient benefits.

I'll not bother you with the historical aspect of this problem, except to say that radiologists strongly opposed the inclusion of benefits for radiology in Blue Cross at the time of its inception. We have worked diligently since that time to have it removed and, as you know, without success.

The report submitted by the Blue Shield committee and approved by the Blue Shield Board is a very reasonable request. It simply asks that benefits for radiology and pathology examinations in hospital outpatient departments be transferred from Blue Cross to Blue Shield by means that are perfectly feasible, without any increase in premium or benefit cost and, in fact, a definite saving.

As you have probably noted, nothing has been reported by either committee, Blue Cross or Blue Shield, relative to one of the main objections to present coverage in Blue Cross; namely, principle. This matter of principle has been discussed many times with hospital administration, the Maryland Hospital Council, and Blue Cross, all to no avail.

Blue Shield is a health insurance plan set up by physicians for the coverage of professional medical expenses incurred by subscribers. In the state of Maryland, all branches of medicine practiced in hospitals are covered by this plan except the services of radiology and pathology. The exclusion of these specialties by hospital administration and Blue Cross has caused the contention. Now before us is a method for at least partial resolution of this matter, simply by transferring the benefits for these services provided in hospital outpatient departments to Blue Shield.

In any group or system where principle is adhered to instead of discrimination, improvement in spirit as well as quality of workmanship is achieved. As a radiologist, let me dwell for a moment on those phases of our recent joint committee discussions that pertain to my own specialty.

An attempt was made during the joint committee meetings to bring out the deficiencies in the method of practice of radiology in Baltimore. The chairman of the Blue Cross Committee felt that determination of costs should be the primary concern of the joint committees investigating this subject, and not quality of practice. I say that principle, quality of workmanship, and cost are all closely allied; and principle and quality should not be forsaken to obtain a lower cost of operation. By the same token, a radiologist should not place himself in a position of jeopardy where he capitalizes on a hospital situation for financial gain and does not deliver the utmost in quality by his own efforts, and the efforts of assistants, when the work load justifies this need. The question in reference to quality relates primarily to the problem: is the radiologist a consultant in his field or is he simply a film-reader? By this I mean, does he actually see the patient? Does he actually correlate the patient's symptoms with those demonstrated by the x-ray examination?

'Place yourself in the position of the patient. Would you not like to know who the radiologist is who will do the interpretation for which the hospital sends you a bill? In only rare instances does the radiologist's name even appear on the bill which you receive. Would you not like for him to be fully aware of your complaints when he does the interpretation of your x-rays? There is only one answer. You would. Is the work load so heavy that there is only time for film-reading and little or no time with the patient, except in those cases that require fluoroscopy? Is the work load so heavy that there isn't possible time to practice this type of radiology? Is the radiologist covering too many locations? If he is, it means he is not giving adequate time at any one place. Is the radiologist doing fifty, sixty, or seventy-five cases a day when, really, if he is doing the job well, he should do no more than twenty-five? Is the radiologist doing all of the procedures that he should be doing or is he relegating the special procedures to someone in another specialty when the fee applied should cover both performance of the procedure and interpretation of the results?

A frequent complaint among hospital radiologists is the inability to obtain professional assistants even though income from the department is quite ample for this need. Too often this income is applied elsewhere within the hospital and at the discretion of the administration, when it should be professional income to improve radiological standards.

Why is there such great reluctance on the part of hospital administration to transfer radiological and pathological benefits to Blue Shield? The real answer to this question seems to be one totally related to control of these specialties by hospitals. If hospitals desire this control, then why do they insist upon Blue Cross being in the picture? Certainly, financially they would be ahead on the inpatient radiology by adhering to the Blue Shield fee schedule. Furthermore, it was brought out in the costs-survey that the non-Blue Cross patient, i.e. the private patient, paying his own way, and the one insured by commercial carriers has to pay more than he would if all services were on a charge rather than a cost basis. I firmly believe that if the standards I have mentioned as being desirable for the operation of a hospital radiology department are met, there would be no real difference in cost to a subscriber regardless of whether payment was made on the basis of cost or the present Blue Shield fee schedule.

Up to this point, my remarks have related mainly to principle and quality in both inpatient and outpatient radiology. Now I want to comment upon the recommendations of the Blue Cross Committee with regard to coverage of these services in hospital outpatient departments.

The third paragraph on Page 1 of this report indicates a savings of $40,000, an amount less than one-tenth of one per cent of the combined Blue Cross-Blue Shield claims volume, if the transfer is made. I think this is a misleading figure which doesn't reflect its true importance. A better figure would be

that $40,000 is equivalent to about 6.5 per cent of the 1961 Blue Cross payments for hospital outpatient department x-ray examinations incidental to trauma, and covered under the basic contract. The reason for these savings is not brought out in the report but should be realized. It is due to the fact that some hospitals, with a high volume of outpatient care, charge far more for x-ray examinations than the fees in the Blue Shield fee schedule, which was developed by radiologists that do both hospital and private office practice. It must be remembered that Blue Cross pays charges, not cost, in its outpatient coverage.

The next paragraph of the report relates to other administrative costs, should there be a transfer of benefits. Mr. Kelly has reviewed this matter at length and believes that an endorsement could be included on all Blue Cross contracts to the effect that the coverage of hospital outpatient department radiology and pathology services as specified in the certificates, are underwritten by Blue Shield. The necessary transfer of premium allocated to these benefits could be handled as an internal accounting adjustment.

The second paragraph on Page 2 indicates that there will be a loss of service benefits to subscribers. This is true only if the hospitals charge the patient a higher fee than provided by Blue Shield. If hospital radiologists are bound by the same regulations (and they should be) as Blue Shield participating radiologists in private practice, there would be no loss of benefits; in fact, there would be savings to subscribers. At this time it should be pointed out that subscribers to the diagnostic endorsement who receive radiology or pathology services in a hospital outpatient department where charges are higher than those in the Blue Shield schedule, have to pay the additional charge regardless of income level. In this situation the under-income subscriber is totally covered in Blue Shield but only partially covered in Blue Cross.

Comment is made in the report to the effect that the public does not desire a change in the method of payment. This point may well be true but it is totally irrelevant. This simply means the public has not been educated in this respect.

Comment is also made to the effect that it would be extremely confusing and completely impractical to administer a program providing payments from different sources, i.e., Blue Shield for hospital outpatient coverage and Blue Cross for inpatient diagnostic coverage. This is by no means impractical. For years radiation therapy has been covered only in the Blue Shield program; hospitals and their radiologists have adjusted here without difficulty.

A recommendation is made in the report that Blue Cross staff undertake a study of paying for outpatient care on some basis other than regular hospital charges. This study would seem totally unnecessary insofar as the professional services are concerned. The mechanism is already available in Blue Shield. The Blue Shield fee schedule is a just and reasonable one that has been prepared by physicians who actually do the examinations.

In summation, I feel the report of the Blue Cross Subscriber's Benefit Committee presents no really valid reasons why the recommended transfer should not be effected. The services under discussion are unquestionably professional. They belong in Blue Shield. The radiological benefits can be covered at a lower cost to the subscriber and pathology care can be covered at no increase in cost to the subscriber.

JANUARY 29, 1964: SPECIAL REPORT ON COVERAGE OF RADIOLOGY AND PATHOLOGY SERVICES TO THE BOARD OF TRUSTEES, MARYLAND HOSPITAL SERVICE, INC., BY THE SUBSCRIBERS' BENEFIT COMMITTEE.

TO: Board of Trustees
Maryland Hospital Service, Inc.

The Blue Cross Subscriber Benefit Committee and the Blue Shield Committee on Diagnostic Services have held a series of meetings to consider the feasibility of transferring coverage for radiology and pathology services at hospitals from Blue Cross to Blue Shield. These joint meetings, which began on May 21, 1962, and concluded on May 28, 1963, were initiated by the Blue Shield Board of Trustees on the basis of a letter received in January 1962 from the State Medical Society reminding the Boards of both organizations of the position taken by the House of Delegates in 1959 on the matter of transferring benefits for radiology and pathology services. Blue Cross agreed to a further discussion of this subject, recognizing, however, that the Board had previously—on December 30, 1959—adopted a statement of position opposing such a transfer of benefits, copies of which had been transmitted to the Medical and Chirurgical Faculty at that time.

At the outset of the discussions, it was understood that a change in method of coverage should only be considered if it would result in a savings to subscribers. Through the cooperation of the Hospital Cost Analysis Service, a survey of costs and charges for x-ray and pathology services in four typical hospitals was made, comparing these figures with the fees for the same services in the Blue Shield schedule. Applying the results of this survey to the hospitals on a state-wide basis showed that a transfer of coverage of inpatient radiology and pathology services from Blue Cross to Blue Shield would result in a substantial increased cost to subscribers. This is due to the fact that Blue Cross pays for these inpatient services on the basis of cost rather than charges.

With respect to outpatient services, the survey showed that a transfer of pathology services would result in no real difference in cost to subscribers, i.e., no potential financial savings to be realized if payments were made on the basis of the Blue Shield fee schedule. On outpatient radiology, however, the survey indicated a potential gross savings of about $80,000 per year. It was estimated that additional claims processing costs necessitated by a transfer of coverage would reduce this figure to a net savings of about $40,000 per year; the latter amount would be less than 1/10th of 1% of combined Blue Cross-Blue Shield claims volume.

While difficult to estimate with any accuracy, there are other areas of administrative costs which probably would increase if the proposed transfer of outpatient radiology and pathology benefits were undertaken. For example, staff feels that two separate and distinct Blue Cross programs would have to be offered, at different subscription rates—one for Blue Cross-only subscribers and one for subscribers to both Blue Cross and Blue Shield. This would involve printing two separate certificate forms and revising all enrollment literature, brochures, and subscription rate schedules. Billing procedures would be vastly complicated, and explanations to groups and subscribers extremely difficult.

The proposed transfer of these out-patient services could well result in a loss of benefits to subscribers. The Blue Cross hospital outpatient benefits provide full coverage—including x-ray and pathology services—in emergency accident cases and for minor surgery. Shifting these two services to Blue Shield would mean payment at the Blue Shield fee schedule amount and guarantee of full coverage only when the subscriber's annual family income was $7,000 or less ($4,500 for an individual subscriber), and if all radiologists and pathologists participated in Blue Shield. While individual radiologists and pathologists might accept the Blue Shield fee as full payment regardless of the patient's income, we see no way in which Blue Shield could contract with hospitals to guarantee acceptance of the Blue Shield payment as full coverage. To effect such a guarantee, every hospital would have to agree to be bound by the Blue Shield fee schedule for radiology and pathology services; under present circumstances this would seem to be unlikely.

In addition to the above considerations, we would again reiterate the point emphasized in the "Statement of Position" on this subject adopted by the Blue Cross Board on December 30, 1959; namely, that there is ". . . no evidence whatsoever that the public desires any change in the present method of providing and paying for these services at hospitals. Traditionally, these services have been included in the hospital departmental structure and billing procedure, and the public considers them as an integral part of the hospital organization." In our opinion, it would be extremely confusing and completely impractical to administer a program providing payments to hospitals from different sources, depending upon whether the service was rendered to an inpatient or an outpatient.

It is your committee's considered recommendation that the coverage of outpatient radiology and pathology services be continued as a basic part of all Blue Cross programs, and that a copy of this report, if approved by the Board, be transmitted to the Blue Shield Board of Trustees.

It is also our recommendation that the Blue Cross staff be instructed to undertake a study of paying for outpatient care on some basis other than the regular hospital charges as is now the case. Despite indications that increased operating costs would probably wipe out the potential gross savings as estimated, we feel that Blue Cross has an obligation to its subscribers to purchase all services at the lowest possible cost.

It is noted that the report of the Blue Shield Committee on Diagnostic Services, while primarily recommending the transfer of *outpatient* radiology and pathology services from Blue Cross to Blue Shield, also includes certain recommendations with respect to *inpatient* radiology, pathology, and other professional services. Specifically, they recommend that coverage for these services be provided in Blue Shield contracts when billings are rendered by physicians who regularly bill all patients for such services, and further that appropriate Blue Shield endorsements be developed for attachment to Blue Cross contracts for those subscribers not now enrolled in Blue Shield. *Since there is presently no instance in the state of Maryland where billings for radiology and pathology services to hospital inpatients are rendered by physicians, the committee feels there is no immediate need to*

make a change in coverage and the matter can be taken up at a later date if conditions change.

Respectfully submitted,
Subscribers' Benefit Committee
SANFORD KOTZEN
WILLIAM D. LYNN, MD
JAMES E. PATTERSON
HUBERT A. POOLE
RUTH R. STARTT
FREDERICK W. WAGNER, JR.
RUSSELL A. NELSON, MD, Chairman

SEPTEMBER 11, 1963: MARYLAND MEDICAL SERVICE, INC., REPORT OF THE BLUE SHIELD COMMITTEE ON DIAGNOSTIC SERVICES TO THE MEMBERS OF THE BOARD OF TRUSTEES, MARYLAND MEDICAL SERVICE, INC.

TO: Members of the Board of Trustees,
Maryland Medical Service, Inc.

The Blue Shield Committee on Diagnostic Services and the Blue Cross Subscriber Benefit Committee have met regularly since May 21, 1962, to consider the feasibility of transferring benefits for radiology and pathology services from Blue Cross to Blue Shield. At the last meeting, on May 28, 1963, the conclusion was reached that further meetings would be useless as all possible exploration of the matter would appear to have been completed, and the two committees could not reach a mutually agreeable joint recommendation to present to their boards. Accordingly, it was decided that each committee would report to its board and that these reports would be exchanged.

It was realized during the initial discussion of the problem that a change in the method of coverage would only be approved by the Insurance Department if it would result in a savings to subscribers, or at very least, no increase in cost and no reduction in benefits. Through the cooperation of the Hospital Cost Analysis Service, a survey of costs and charges for x-ray and pathology services in four hospitals, selected on the basis of size, location, and adequacy of cost accounting practices, was conducted. A copy of the survey is attached hereto. Briefly, it indicates the transfer of coverage of inpatient radiology and pathology services from Blue Cross to Blue Shield would result in increased cost to subscribers. This is due, of course, to the fact that Blue Cross pays for such services on the basis of cost rather than charges or a fee schedule, and if a transfer was made payment would have to be made on one of the latter two bases.

To a certain extent the opposite was true in the case of those services provided in hospital out-patient departments. Blue Cross pays for all services in out-patient departments on the basis of charges and the survey indicates that in the four hospitals under study the weighted average charges for x-ray services were somewhat higher than if they had been paid under the Blue Shield schedule of benefits, which is also similar to the schedule in effect for Workmen's Compensation cases. The survey indicated that there was no essential difference between the hospitals' weighted average charges for out-patient pathology services and the benefits in the Blue Shield fee schedule; thus, there was no potential financial saving to be realized from a transfer of these services. The later meetings of the committees were devoted primarily to consideration of out-patient services, your committee having realized that further exploration of the transfer of inpatient services would be fruitless because of the substantial increased cost to subscribers. The Blue Shield Committee ultimately made the following recommendations:

1. That coverage of all *out-patient* radiology and pathology services provided to Blue Cross subscribers be transferred from Blue Cross to Blue Shield; and that an appropriate rider or endorsement be developed by Blue Shield for inclusion in Blue Cross contracts so that there would be no loss of coverage to those subscribers who are not Blue Shield members.
2. That an appropriate clause be added to all Blue Shield contracts to provide coverage, according to Blue Shield schedules, for radiology, pathology, and other professional services provided to covered hospital inpatients by physicians who regularly bill all their patients for such services.
3. That an appropriate matching endorsement be developed by Blue Shield for attachment to the Blue Cross certificates so that subscribers to only the Blue Cross Plan may have protection for such inpatient professional services by physicians who regularly bill all their patients for such services.

The potential gross savings to subscribers from the transfer of coverage of out-patient radiology and pathology from Blue Cross to Blue Shield has been estimated at about $80,000 per year; this would amount to about 2/10 of one percent of total Blue Cross claims volume. It has been pointed out that this saving would be at least partially offset by additional administrative cost in claims processing, staff estimating that it would amount to close to 50% of the anticipated gross savings.

If these services were transferred to Blue Shield, all hospitals should agree to be bound by the fee schedule in effect for all subscribers in order to guarantee the availability of service benefits.

It is understood that the chairman of the Blue Cross Subscriber Benefit Committee, in reporting to his board, will take the position that Blue Cross must either support the Blue Shield Committee's recommendations or alter the method of payment by Blue Cross for care provided in hospital out-patient departments so that, under whatever approach is adopted, subscribers will receive present contract benefits at the lowest possible cost. The Blue Shield Committee feels strongly that the first alternative is that which will best prevent further hospital or third-party interference with the practice of medicine. It would also allow the patient freedom of choice in selecting a physician in private practice or a hospital radiologist for x-ray examinations. Under the present Blue Cross certificate, out-patient ambulatory cases (72 hour traumatic) involving subscribers enrolled only under Blue Cross are only covered if they are examined at hospitals. This method of coverage in Blue Cross is certainly discrimination against the physician in private practice in favor of the hospitals.

It is your committee's recommendation that the Blue Shield Board approve the committee's proposals with regard to the coverage of out-patient radiology and pathology as set forth herein, and that the Blue Cross Board be urged to take similar favorable action in order that these recommendations may be implemented promptly.

Respectfully submitted,
Committee on Diagnostic Services
C. RODNEY LAYTON, MD
DEXTER L. REIMANN, MD
WILLIAM G. SPEED, III, MD
CHARLES N. DAVIDSON, MD, Chairman

FEBRUARY 11, 1963: HOSPITAL COST ANALYSIS SERVICE, INC. LETTER/REPORT TO MR. REGINALD H. DABNEY, EXECUTIVE DIRECTOR, MARYLAND HOSPITAL SERVICE, INC., MARYLAND MEDICAL SERVICE, INC.; AND THEIR REPORT ON OPERATING COSTS IN MARYLAND HOSPITALS FOR THE CALENDAR YEAR 1961—MEMORANDUM, TO SUBSCRIBER BENEFIT COMMITTEE, MARYLAND BLUE CROSS PLAN AND SPECIAL COMMITTEE ON DIAGNOSTIC SERVICES, MARYLAND BLUE SHIELD PLAN.

Mr. Reginald H. Dabney
Executive Director
Maryland Hospital Service, Inc.
Maryland Medical Service, Inc.
7800 York Road
Baltimore 4, Maryland

Dear Mr. Dabney:

From the questions asked at the last meeting of The Blue Cross Subscribers Benefit Committee and The Blue Shield Special Committee on Diagnostic Services and from a subsequent meeting with representatives of The Medical and Chirurgical Faculty, it appeared that an expansion of our report to you dated October 12, 1962 would be helpful.

Conclusions

As pointed out in the original study, it was not practical for us to segregate the work or costs of the two departments between inpatient and outpatient activity.

Assuming that both the inpatient and outpatient activities of the x-ray and laboratory departments of the four hospitals are reimbursed at their cost, then if the hospitals were reimbursed based on the Blue Shield Schedule of Benefits, the reimbursement would be approximately $941,000 higher and if based on the Hospitals' Schedule of Charges it would be approximately $1,043,000 higher.

After making certain assumptions described later, we applied various ratios developed in the four hospitals to the forty general hospitals in Maryland for the year 1961. The reimbursement, if based on the Blue Shield Schedule of Benefits would be approximately $5,098,000 higher, and if based on the Hospital Schedule of Charges, it would be approximately $5,631,000 higher than the reimbursement based on the hospitals' cost for the same services.

Additional Information Concerning
The Hospitals In The Original Study

We have taken the x-ray and laboratory departmental cost

Schedule A

Blue Cross Portion
Of X-Ray and Laboratory Department Costs
(By Elements)
Compared With Blue Shield Schedule
And With Hospital Charges
Of The Four Hospitals In The Original Study

		Cost To Blue Cross-Blue Shield If Payment Based Upon		
		Hospital Costs	*Blue Shield Schedule*	*Hospital Charges*
X-Ray				
Direct Costs:				
Salaries	$190,766.18			
Supplies	101,667.91			
Indirect Costs	76,406.15			
Depreciation	29,513.27			
Total		$398,353.51	$ 633,382.08	$ 728,986.92
Laboratory				
Direct Costs:				
Salaries	$316,588.95			
Supplies	110,544.70			
Indirect Costs	122,753.30			
Depreciation	43,708.86			
Total		593,595.81	1,299,974.82	1,305,910.78
Combined		$991,949.32	$1,933,356.90	$2,034,897.70

the percentage of Blue Cross business done by the hospital and combined the results to show the cost attributable to Blue Cross for these services. We then computed the payment based on the Blue Shield Schedule of Benefits and on the Schedule of Hospital Charges.

We have prepared and shown below the breakdown of cost into salaries, supplies, indirect costs (appropriate portion of such items as administration, housekeeping, repairs, heat and light, etc.), and depreciation. The results are shown in Schedule A.

Application of Ratios Developed In The Study of Four Hospitals To Forty General Hospitals in Maryland

Each six months the hospitals submit to us a Hospital Statement of Reimbursable Cost on which they report the direct departmental costs. These are the costs that are regularly verified by us. A copy of the form and the instructions for its preparation are attached. The direct costs are broken down into salaries and other expenses. Because no attempt is made on these reports to distribute the indirect costs (overhead) to the departments benefited, it was necessary for us to determine the indirect costs applicable to the x-ray and laboratory departments. The indirect costs (including depreciation) of the x-ray and laboratory departments in the four hospitals in the original study averaged 34.58% and 38.59% respectively.

We assumed that these averages would be applicable to the hospitals on a statewide basis, and by applying them to the direct costs reported by each hospital for the year 1961, we were able to arrive at a total x-ray and laboratory cost for the hospital.

We then applied the inpatient Blue Cross utilization experience of each hospital to its departmental costs (including indirect costs and depreciation) to arrive at the Blue Cross x-ray and laboratory costs. These were then added to obtain the total Blue Cross x-ray laboratory costs for the forty general hospitals for 1961.

Assuming that the same relationships between costs, Blue Shield charges and hospital charges exist in the forty hospitals as in the four hospitals included in the study, we applied the ratios reported to you October 12, 1962 to the respective Blue Cross costs to arrive at the Blue Shield charges and the hospital charges for all the hospitals. The results of this work are contained in Schedule B.

In order that the members of the committees may better understand the Hospital Cost Analysis Service, its purpose and its complete independence of the hospitals, Blue Cross-Blue Shield and the state, I have asked Mr. Kelly to distribute copies of *Some Facts To Know, A Handbook For Maryland Hospital Trustees* published by The Hospital Council of Maryland, Inc. Attention is particularly directed to pages 12 and 13.

I am attaching a list of the officers and directors of The Hospital Cost Analysis Service and the agency by whom each

SCHEDULE B

Blue Cross Portion
Of Hospital X-Ray and Laboratory Department Costs for 1961
Compared With Blue Shield Schedule
And With Hospital Charges
Of The Forty General Hospitals in Maryland

	Cost To Blue Cross-Blue Shield If Payment Based Upon		
	Hospital Costs	*Blue Shield Schedule*	*Hospital Charges*
X-Ray	$2,086,592.87	$ 3,317,682.66	$ 3,818,464.95
Laboratory	3,249,403.38	7,116,193.40	7,148,687.44
Combined	$5,335,996.25	$10,433,876.06	$10,967,152.39

was appointed so the committees will know who they are and to show the high caliber of public spirited men who direct the service.

I am also attaching a copy of our Report on Operating Costs in Maryland Hospitals for the calendar year 1961, the latest one available.

If we can provide any further assistance to the Committees, we shall be glad to do so.

Very truly yours,
A. Rutherfoord Holmes
Manager

MEMORANDUM

TO: Subscriber Benefit Committee, Maryland Blue Cross Plan
Special Committee on Diagnostic Services, Maryland Blue Shield Plan

Since the October 15, 1962, joint meeting of the Blue Cross Subscriber Benefit Committee and the Blue Shield Special Committee on Diagnostic Services, several committee members have called to ask for further information on various aspects of the matter discussed. It was also suggested that a summary be prepared which would give the basic information currently available in a form which, while condensed, was more complete than minutes of the meeting. The following summarization is designed to serve this purpose.

A survey made in 1959 and kept up to date since then indicates that the great majority of subscribers to the Blue Plans receive coverage for radiology and pathology services through benefits provided by their Blue Cross plans, and that the underwriting of such benefits through Blue Cross is more prevalent in the realm of inpatient than outpatient services.

About 83.2% of the subscribers in the United States receive inpatient radiology coverage under their Blue Cross contracts, with the remaining 16.8% being covered by Blue Shield or, in a very few instances, having no coverage. The comparable figures

	X-Ray	*Laboratory*
Hospital charges for covered inpatient services, all programs ..	$2 712,626	$4,338.919
Cost to Blue Cross under reimbursable cost formula	1,482,309	1,972,236
Cost if paid under Blue Shield schedule	2,356,871	4,319,197
Saving by paying under cost formula rather than Blue Shield schedule	874.562 (37.1%)	2,346,961 (54.3%)
Saving by paying under cost formula rather than hospital charges	1.230,317 (45.4%)	2,366,683 (54.5%)
Hospital charges for covered outpatient services, all programs ..	613,565	107,716
Cost to Blue Cross if on cost formula	335,281	48.962
Cost if paid under Blue Shield schedule	533,097	107.227
Saving by paying under Blue Shield schedule rather than hospitals' charges	80,468	489

	Blue Cross	*Blue Shield*	*Combined Blue Cross And Blue Shield*
Total incurred claims, 1961	$35,375,608	$9,335,582	$44.711.190
Change in incurred claims if inpatient radiology converted from Blue Cross to Blue Shield	—1,482,309 (4.2%)	+2,356.871 (25.2%)	+ 874,562 (1.95%)
Change in incurred claims if inpatient laboratory converted from Blue Cross to Blue Shield	—1,972,236 (5.6%)	+4,319.197 (46.4%)	+2,346.961 (5.25%)
Change in incurred claims if both inpatient radiology and laboratory converted from Blue Cross to Blue Shield	—3,454.545 (9.8%)	+6,676.068 (71.5%)	+3.221.523 (3.79%)
Change in incurred claims if outpatient radiology converted from Blue Cross to Blue Shield Schedule	— 613.565 (1.7%)	+ 533,097 (5.7%)	— 80.468 (0.18%)
Change in incurred claims if outpatient laboratory converted from Blue Cross to Blue Shield Schedule	— 107,716 (0.3%)	+ 107,227 (1.1%)	— 489 (0.001%)
Change in incurred claims if both outpatient radiology and laboratory converted from Blue Cross to Blue Shield Schedule	— 721,281 (2.0%)	+ 640,324 (6.8%)	— 80,957 (0.181%)

for pathology coverage are 96.6% under Blue Cross or 3.4%, Blue Shield.

To retain proper perspective, coverage of outpatient department services must be distinguished between those for emergency accident cases and non-emergency minor surgical cases. In the first category, 76.6% of the subscribers receive coverage for radiology and 88% for pathology services through Blue Cross, with the remainder being covered by Blue Shield or, again in a few instances, having no coverage. In the minor surgical category Blue Cross covers 54% of the subscribers for radiology and 69% for pathology; only about half of the remainder have coverage under Blue Shield, the others having no coverage at all.

In Maryland the present method of underwriting such coverage on both the inpatient and outpatient sides is through the medium of Blue Cross. The hospitals are reimbursed for all inpatient services on the basis of per diem cost or charges, whichever is less. Covered outpatient services are paid for on the basis of the hospitals' individual charges.

During the summer of 1962, the Hospital Cost Analysis Service, Inc. undertook a survey to determine the cost to Blue Cross and/or Blue Shield of covering radiology and pathology services, in both inpatient and outpatient categories, on the basis of the prevailing Blue Cross reimbursable cost formula, hospital charges, or the current Blue Shield fee schedule. This study showed conclusively that the cost of providing these services to inpatients, where reimbursement is on a cost basis, is about half what it would be if the same services were provided on a fee-for-service basis through the Blue Shield fee schedule currently in effect. In hospital outpatient departments, where covered services are paid for by Blue Cross on the basis of hospitals' charges, the survey indicates that the cost of radiology coverage would be some 13% cheaper if paid for on the basis of the Blue Shield fee schedule, while there would be no appreciable difference for pathology.

It must be remembered that if this coverage were provided by Blue Shield there might be a loss of the paid-in-full service benefit feature to those subscribers whose annual incomes exceeded the current Blue Shield service benefit levels of $4,000 for individuals and $7,000 for families. Through the Maryland Radiological Society most radiologists have agreed to accept the Blue Shield schedule as payment in full for covered services regardless of income although they are not contractually bound to do so. The pathologists have made no such informal commitment. With coverage by Blue Cross, as it now exists, subscribers have paid-in-full benefits regardless of income.

For ready reference the full text of the Hospital Cost Analysis Service, Inc. survey is reproduced herewith.

In order to relate the results of the Hospital Cost Analysis Service, Inc. survey to actual Maryland Blue Cross and Blue Shield figures, it was decided to apply 1961 Maryland claims figures against the percentages revealed in the survey. The following figures show the net changes in 1961 Blue Cross and Blue Shield claims cost which would have resulted in coverage of radiology and patbology had they been transferred from Blue Cross to Blue Shield, assuming that the HCAS figures are valid on a statewide basis.

Essentially these figures point up the fact that there would be a substantial net increase in cost to subscribers for inpatient services if the coverage were transferred from Blue Cross to Blue Shield; and that there would be a modest reduction in cost of outpatient services from such a transfer, coupled with the possible loss of some service benefit rights. Additional administrative costs would also have to be figured upon in any such transfer.

OCTOBER 12, 1962: LETTER FROM HOSPITAL COST ANALYSIS SERVICE, INC., TO MR. REGINALD H. DABNEY AS EXECUTIVE DIRECTOR, MARYLAND HOSPITAL SERVICE, INC. AND MARYLAND MEDICAL SERVICE, INC.

Mr. Reginald H. Dabney, Executive Director
Maryland Hospital Service, Inc.
Maryland Medical Service, Inc.
7800 York Road
Baltimore 4, Maryland

Dear Mr. Dabney:

At the last meeting of the Blue Cross Subscribers Benefit Committee and The Blue Shield Special Committee on Diagnostic Services, the Hospital Cost Analysis Service was requested to work with members of your staff in finding the cost to your organizations for services rendered by the x-ray and laboratory departments of the hospitals in Maryland when reimbursed on a cost basis and to determine what the cost to your organizations would be if reimbursement for the services of these two departments were made on the basis of the Blue Shield Schedule of Benefits.

After exploring the many problems related to each of the various approaches that might be taken, it was decided that with the information readily available it was impractical, if not impossible, to determine the actual cost to the hospitals of services

rendered in these departments to Blue Cross subscribers as distinguished from other patients. The main reason for this is that there is not available a listing of the specific services rendered to Blue Cross subscribers and therefore it would be impossible, even assuming the validity of a point evaluation method, to determine the percentage of the work in a particular hospital that was done for Blue Cross subscribers.

It was decided instead that we would take the opposite approach, namely, to determine the total cost of all the services rendered by each of these departments and then to value these same services on the basis of the Blue Shield Schedule of Benefits. The third part of our work involved valuing the same services rendered on the basis of each hospital's own schedule of charges.

We were able to obtain realistic departmental costs in four hospitals. These included a hospital with a medical school affiliation, one large and one small city hospital, and a large county hospital.

In order to simplify the presentation and to avoid identification of the hospitals, we have shown each hospital's cost at a standard of $1. The total value of the services on the Blue Shield Schedule of Benefits and on the hospital's schedule of charges are shown in their respective relationship to the $1 cost standard.

Fox example assume:

		Would be shown as
Departmental Cost	$175,000	$1.00
Blue Shield Scheduled Benefits	262,500	1.50
Hospital Charges	350.000	2.00

The results of our study are shown in the following schedule:

	Weighted	*HOSPITAL*			
X-RAY	*Average*	*#1*	*#2*	*#3*	*#4*
Cost	$1.00	$1.00	$1.00	$1.00	$1.00
Blue Shield Schedule	1.59	2.29	1.89	1.08	1.46
Hospital Charges	1.83	2.01	2.25	1.55	1.46
LABORATORY					
Cost	$1.00	$1.00	$1.00	$1.00	$1.00
Blue Shield Schedule	2.19	2.56	2.27	2.25	1.64
Hospital Charges	2.20	1.81	2.40	2.32	1.69

The present form of the Hospital Statement of Reimbursable Cost was designed to allocate departmental cost between the inpatient and outpatient functions of the hospital and not to allocate overhead and other costs to the various departments of the hospital. It was therefore impossible for us to use any of the cost information which has been reported to us by the hospitals previously. Instead, it was necessary to work with a number of hospitals in Maryland which in the last year or two have undertaken cost finding procedures based upon the "step-down" method. Basically this method comprehends the allocation of all indirect cost as well as direct cost to the departments they benefit—and its use results in far more accurate departmental costs.

It was necessary for us to visit each of the four hospitals which had agreed to cooperate in the study. On this visit we had three main objectives:

1. To determine that the cost finding covered a recent period of at least six months duration, that it had been properly prepared and that the allocations used were fair for the conditions prevailing at the particular hospital.
2. To obtain schedules or reports listing in detail all the procedures, x-rays and other work done in the x-ray and laboratory departments during the period covered by the cost finding. We then had to value this work in accordance with the Blue Shield Schedule of Benefits.
3. The valuation of the work included in number two above based upon the hospital's own Schedule of Charges.

As might be expected we found that the classification of x-ray examinations and laboratory procedures was not uniform in all the hospitals, nor was it always possible to determine precisely which specific x-ray examination or laboratory procedure had in reality been performed. For example, whether No. 007 (x-ray of the eye for foreign body) at a value of $15 or No. 008 (x-ray of the eye for foreign body localization) at $25 had been performed. In each instance, wherever doubt arose as to the classification of a procedure or film, we always used the examination classification which would result in the lower schedule of benefits. To have done otherwise would make our study subject to challenge.

We are satisfied that at each of the hospitals selected, the accounting and cost finding procedures were such as to assure the reasonable determination of total departmental costs and that the results shown in the foregoing tabulation are accurate.

If we can provide any further assistance to the Committees, we shall be glad to do so.

Yours very truly,
A. Rutherfoord Holmes,
Manager

APPENDIX 2

MAY 29, 1964: LETTER TO DR. PILLSBURY RELATING TO FOLLOWING ENCLOSURES:
MAY 16, 1964: A REPORT OF RECENT LOCAL BLUE SHIELD AND BLUE CROSS ACTIVITIES RELATED TO RADIOLOGY AND AN EVALUATION OF RADIOLOGIC PRACTICE TO MEMBERS OF THE MARYLAND RADIOLOGICAL SOCIETY (RECOMMENDATIONS IN REPORT ADOPTED) AND IMPROVED RADIOLOGICAL COVERAGE VS. IMPROVED HOSPITAL CONTRACTS FOR RADIOLOGISTS, BY JAMES M. DENNIS, MD.

William A. Pillsbury, MD
Secretary
Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore, Maryland
21202

Dear Dr. Pillsbury:

A few days ago, I corresponded with you regarding the out come of the proposed transfer of radiology and pathology benefits from Blue Cross to Blue Shield. Since we were unable to move forward by this means, I felt it advisable to re-assess our position as radiologists.

Enclosed, you will find a copy of a report presented to the Maryland Radiological Society, May 16, 1964. The recommendations of this report were adopted by the Society. I hope that this approach will prove worthwhile.

Also enclosed is a copy of some comments made by Dr. John M. Dennis.

Sincerely yours,
Charles N. Davidson, MD

A REPORT OF RECENT LOCAL BLUE SHIELD AND BLUE CROSS ACTIVITIES RELATED TO RADIOLOGY AND AN EVALUATION OF RADIOLOGIC PRACTICE.

To Members of The Maryland Radiological Society:

Enclosed is pertinent material on the recently completed cost survey and recommendations related to the proposed transfer of radiology and pathology benefits from Blue Cross to Blue Shield. The transfer of benefits was requested by the Medical and Chirurgical Faculty of Maryland.

From the standpoint of cost alone, it seemed inadvisable to request a transfer of inpatient radiology benefits at this time; however, we hoped to obtain a transfer of outpatient benefits with a definite saving in cost. The Blue Shield Board approved this transfer, but for it to be effective, subscriber benefits in Blue Cross had to be relinquished. In addition to the effort made at committee level with Blue Cross members to accomplish a recommendation for the outpatient transfer, another plea (see enclosure) was made to the Blue Cross Board at its meeting on March 25, 1964, when this matter was being considered. The Blue Cross Board turned down our request. The matter stands now as before, i.e., no change.

It is unfortunate that Blue Cross would not cooperate to the extent of at least granting the outpatient benefits. A simple analysis of the matter indicates that hospital administration also is opposed. Hospital administration wants to continue complete control of radiology and pathology. Any change for improvement from our point of view means a "foot in the door," and hospitals want no part of this invasion.

Concerted effort is being made to extend outpatient and office coverage of radiology and pathology benefits to additional subscribers. The following benefits have been approved jointly by Blue Shield and Blue Cross:

1. The addition of benefits for radioactive isotope diagnostic studies to the present endorsement covering radiology and pathology services.
2. The development of a new diagnostic endorsement identical with (1) above but eliminating the 20 per cent co-insurance provision to be offered to groups at appropriate rates to be determined by the actuary; and further that the offering of the diagnostic endorsements be extended to all groups and when deemed practical from an underwriting standpoint, to non-group and direct pay subscribers.

Payments for these services are made, as previously, according to the method of billing; namely, if the radiologist bills for the service, Blue Shield makes the payment, and if the hospital renders the bill, Blue Cross provides the payment. Every hospital radiologist can obtain these outpatient benefits through Blue Shield for those subscribers now covered if he is concerned enough to take action at his hospital. It is hoped that the Insurance Commissioner will approve the additional coverage

described above, which is to be presented to him in the near future.

Since we have not been able to obtain the necessary factual material to bring about the transfer of radiology from Blue Cross to Blue Shield, what other methods of approach are possible to achieve our goal of better radiologic patient care? Basically, only two conditions are necessary: (1) higher standards of radiologic practice and (2) unity of radiologists. If these two conditions had been fulfilled earlier, there would be no necessity for our continued activity with Blue Cross to help solve our hospital differences in radiologic practice.

In many instances our economic problems stem directly from a lack of quality control. Quality of radiologic practice is totally or ideally fulfilled only when personal care is rendered, which means seeing the patient and correlating symptomatology with radiologic findings. Until this is done, there probably will be contention between the hospital and the radiologist as to how much of the professional portion (that part above cost) of the radiologic fee is due the radiologist. When the radiologist takes the time to practice in this manner, he can unquestionably justify that portion of the fee above cost without criticism by either hospital or other members of the medical profession. This can be done in nearly all instances of hospital and office practice. This method of practice necessarily limits the number of patients that any one radiologist can examine in a given period of time. Unquestionably, standards of practice are elevated and quality of practice is foremost. By such means, the economic issue is automatically solved, the professional portion of the radiologic fee is commensurate with the service rendered, and "film reading" as such disappears. Beyond any doubt, the radiologist's problems are due to the type of radiology practice in which he is a "film reader", i.e., seeing and interviewing only those patients where fluoroscopy is necessary. This method of practice is most undesirable and should be condemned. Futhermore, it creates poor patient-radiologist relationship. The situation leads to further complications, for the radiologist practicing in this manner tends to spread his efforts thinner and thinner in an attempt to cover more and more locations. He is a very busy person but doing an inadequate job.

Another weakness in the specialty of radiology is the lack of interest of certain radiologists in special procedures. In nearly all instances, these procedures should be done by the radiologist, yet there are hospitals where physicians in other specialties perform the studies while the radiologist may be "film reading" or away from the hospital or disinterested. It is quite likely that the fee applied to the radiologic procedure covers both performance of the procedure and interpretation, yet the patient will receive an additional bill for performance of the procedure by the other physician. The *Guide for Conduct of Radiologists in Relationship with Institutions,* prepared by the American College of Radiology, indicates that an average patient load of approximately 25 cases per day is about all that any one radiologist can provide. This certainly is true in private practice. In hospital practice where lengthy special procedures are necessary, the number of patient studies must be even less.

The American College of Radiology has recently advocated the separation of professional fees from hospital costs. Several years ago, the Maryland Radiological Society. also recommended a division of fees from professional and technical portions. Before such a separation can equitably and ethically take place, i.e., a true separation of costs and professional income, radiologic practice has to be standardized with quality control included. "Film reading" alone does not represent adequate radiological patient-care, and the radiologist is not justified in receiving the full professional fee (all of the fee above costs) when he only partially fulfills his duty.

The lack of cooperation or unity on the part of radiologists is frequently appalling. This seems particularly true when economics or allied topics are under discussion. How easy it would be if we would only willingly and earnestly get together, discuss the issues at hand, and act jointly to solve them. By cooperating to the fullest extent and elevating our standards of practice, we should be able to solve any hospital situations where quality needs to be improved and economics are handled improperly. It seems paradoxical that radiologists have a buyers market before them yet act as though a depression is at hand. The local cost survey indicates that hospital radiology is being done cheaply. The reasons for it seem quite apparent. We must not let cheap radiology substitute for quality care.

We realize that this concept of practice cannot be instituted rapidly both from the standpoint of present radiologist-hospital contracts and the even greater need for radiologists. There will necessarily be a period of study, evaluation, and education. This method of radiologic practice is not new, for it is now being practiced in this area and elsewhere by some radiologists. The adoption of this type of radiologic practice is completely the task for the radiologists to perform. Hospitals are not going to demand it when they are realizing a profit from our inadequacies. Hospitals will only require it when such a program is necessary for accreditation. Thought should be given to the possibility of correcting the condition through channels of hospital accreditation. Even though this change or concept may be a slow one to fulfill, it seems imperative to do so if we are to improve radiologial patient-care and attract young able medical men into our specialty.

A third area in need of study and application of quality control if necessary is in the large segment of general medical practice where radiologic examinations are included in patient care. This area will be difficult to study, and no doubt it will present many problems and consume much time to arrive at an evaluation. If improved radiologic care is needed in this area, the medical profession should be the first to act. The recent Code of Ethics set up for office practice of radiology in Maryland by the Maryland Radiological Society is not only proving worthwhile in accomplishing improvement in radiologic practice by radiologists but is also improving radiologic patient-care by non-radiologists.

Summary

In summary radiologists need to:
1. Unite
2. Insist upon improved patient care (quality radiological practice)

Recommendations

The Maryland Radiological Society appoint a standing committee to:
1. Study and set up standards in radiologic practice to promote improved patient care.
2. Determine a means of encouraging the cooperation and participation of every practicing radiologist, (hospital and private) in this method of radiologic care.
3. Seek the advice of teachers in the field of radiology and encourage their participation in a Residency Training Program to promote total radiologic care.
4. Request the Medical & Chirurgical Faculty of Maryland to participate in a program of improved radiologic care in the field of general practice if such a need exists.

Presented before The Maryland Radiological Society
May 16, 1964

Charles N. Davidson, MD
115 Medical Arts Bldg.
Baltimore, Maryland 21201

IMPROVED RADIOLOGICAL COVERAGE vs IMPROVED HOSPITAL CONTRACTS FOR RADIOLOGISTS

Unfortunately, I am unable to attend the annual meeting of the Maryland Radiological Society this year, but have recently had the opportunity to review a rough draft of Dr. Charles Davidson's report on Blue Cross and Blue Shield problems and would like to support Dr. Davidson's position regarding improvement of radiologists contracts through improved service to hospitals. From personal observation over the past several years, it is my belief that if proper service is rendered in a radiology department, one can gain strong support from fellow physicians for an ethical contractual arrangement with the hospital. This belief has been further substantiated during the past year when my associates and I had the occasion to negotiate an ethical contract with a hospital administrative body. While in reality the market for radiologists belongs to the seller, it is obvious that in this community one cannot depend upon this fact to obtain an ethical contract. While the local radiologists have spent a great deal of time, effort, and money battling the Hospital Association and Blue Cross for more ethical contracts, we are no further along in reaching an ideal situation then we were several years ago. It seems to me that now is the time to reassess our own position from the standpoint of the service which we are rendering. Radiologists cannot expect to collect a large percentage of the income of a department if they are only "film readers" spending two or three hours a day in the hospital because their obligation to the hospital and medical staff goes much further. The radiologists should be available at all times for consultations with referring physicians and should concern themselves with administrative functions of the hospital and not leave them entirely to other physicians and the administrative staffs.

Local radiologists are missing a great opportunity to improve their image in the eyes of their fellow practitioners, the hospital administrative boards and the public in general by being content to be "film readers" and doing only a limited number of radiological procedures, most of which are no longer in a special

class. The horizon of radiology is broadening, and most radiologists are missing an excellent opportunity to involve themselves in the special diagnostic procedures such as angiocardiography, lymphangiography, vascular catheter studies, radio-isotope work, etc. If radiologists would concern themselves with doing the complete diagnostic study, including knowing and talking to the patient, passing the catheter, etc., rather than being just a "film reader," his stature in the hospital and community would be greatly improved. Through this improvement in stature, plus increased departmental income, would come improved contractual arrangements for the radiologist, not only from the standpoint of personal financial gains, but also in the form of departmental support and development. I realize that many radiologists say that they do not have time to perform these special procedures, but whose fault is this other than their own? Even if they do not know how to perform these studies in their entirety or do not have time to perform them, they then must be willing to make sacrifices to learn and to spend the time so that these procedures are performed completely by the radiologists and not by the surgeon. If the hospital staff has competent surgeons to correct vascular defects, etc., then the radiologist on that staff should be equally competent and interested in performing the radiologic studies necessary to make the diagnosis and outline the lesion for him. I am cognizant of the factors involved from the standpoint of obtaining the necessary assistance from the hospital, but someone has to put the first foot forward, and it should be the local radiologists.

My experience and that of my associates during the past year, in negotiating with the other institution, indicates to us that through the service rendered in our current position we obtained strong voluntary support from the other medical staff. I am convinced that any radiologist in this state who would be willing to sacrifice time and money for a short time would be adequately compensated over the long haul, not only from the standpoint of personal finances and department development but also from the personal satisfaction of being a broadened and more enlightened radiologist.

The Department of Radiology of the University Hospital will accept interested local radiologists for special procedure training on a part-time basis without obligation on the part of the radiologists. A reasonable schedule would have to be set up whereby the radiologist would have to spend one day a week for several weeks. The number, at any one time, would necessarily have to be limited as the departmental residents also must be trained.

JOHN M. DENNIS, MD

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:
Proposed Medicolegal Code of Cooperation:*

PREAMBLE

Acknowledging that substantial part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of a lawyer and a physician; that the public interest and individual problems in these circumstances are best served only as a result of cooperative efforts of all concerned; that members of both the legal and medical professions share an obligation to the individual and to society, we the members of the Maryland State Bar Association, the Baltimore City Bar Association and the Medical and Chirurgical Faculty of the State of Maryland, do adopt and recommend the following declaration of principles as standards of conduct for attorneys and physicians, in interrelated practice.

MEDICAL EXAMINATIONS AND REPORTS

1. *Authorization of Patient Required:* A physician shall furnish to any person, any information concerning the history, physical condition, diagnosis or prognosis of the physician's patient only upon the signed authorization of the patient (or, in the case of a minor, of the minor's parent or guardian), or where authorized by law.**
2. *Reports to Patient or his Attorney:* The patient, or his attorney, shall be entitled upon written request, to a prompt report from the attending physician, concerning the history, findings, treatment rendered, diagnosis and prognosis. The physician's fee for such report should be commensurate with the time and effort devoted to its preparation.
3. *Request for Report:* When a medical report is requested of a physician, whether he be an attending physician, consulting physician, or examining physician, the lawyer requesting the report should make clear in his request the specific information desired; should disability evaluation and the prognosis be desired, the lawyer should so specify.
4. *Examination of Adverse Party:* Where there has been an examination of an adverse party, the examining physician shall not furnish to the person examined or his attorney or anyone else other than the person arranging for the examination a copy of his report or any information concerning his findings on such examination. The examining physician, acting for a party adverse to the person he is examining, should, where taking a medical history, attempt to elicit only such facts as are pertinent to his examination.

MEDICAL TESTIMONY

1. *Conference Before Trial:* In order that the patient and client may have his case properly presented to the Court or other tribunal and to see that justice is done, it is the duty of each profession to present fairly and adequately the medical evidence in legal controversies. To arrive at that end pre-trial conference between the lawyer and the physician regarding medical testimony is encouraged and recommended. The members of each profession shall do their utmost to co-operate with the other in arranging a time and place satisfactory to both for such a meeting.
2. *Subpoena for Physician: Conference:* A subpoena should not be issued to any physician without prior notice and conference with such physician, where possible, concerning the matters regarding which he is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary.†
3. *Cooperation with Court:* It is recognized that the proper and efficient dispatch of the business of the courts cannot depend upon the convenience of litigants, the lawyers or the witnesses, including physicians who may be called to testify; both the lawyer and the physician should recognize, accept and discharge their obligation to aid and co-operate with the courts in the presentation of medical testimony.
4. *Arrangement for Court Appearance:* In arranging for the attendance of a physician at a trial or other legal proceeding, the lawyer should always have due regard and consideration for the professional demands upon the physician's time, and accordingly, the lawyer should, whenever possible, give the physician reasonable notice in advance of his intention to call the physician as a witness, and of the probable date on which the physician will be expected to testify.‡ The lawyer should also advise the physician to bring with him to court such records as the lawyer or the

* Adopted, see minutes.

** Examination made in Workmen's Compensation Cases fall in this category.

† Careful preparation of a case requires that the lawyer issue a subpoena for each important witness including physicians. A lawyer should explain to the physician that the issuance of a subpoena for the physician is in accordance with the standard practice of procuring physicians as witnesses.

‡ It must be understood that the lawyer does not control the date of trial in any case since this is a matter in the sole control of the court.

physician may need for the proper presentation of the physician's testimony. Furthermore, during the course of the trial the lawyer should endeavor to keep the physician advised from time to time as to the approximate hour when he will be called to the witness stand; and upon the physician's appearance at the hearing at the hour agreed upon the lawyer should endeavor to arrange with the court for the prompt calling of the physician to the witness stand.

When arrangements are later cancelled for the court appearance and the physician has cancelled his regular appointments, he shall, nevertheless, be entitled to be paid a reasonable fee.

5. *Fees for Expert Testimony:* A reasonable expert witness fee is a proper and necessary item of expense in litigation involving medical questions. When a physician is called to testify as an expert witness he should be paid such expert witness fee as may be agreed upon between the physician and the lawyer calling him. In every instance in which the lawyer makes arrangements for expert testimony it shall be the duty of the lawyer to see that the physician is paid his fee.
6. *Contingent Fees:* Neither the physician called as a witness nor the lawyer so calling him shall invite or enter into any arrangement whereby the making of a charge for the physician's appearance as a witness or for the giving of testimony, or the amount of any such charge, shall be contingent on the outcome of the litigation or on the amount of damages awarded in the case.
7. *Physician Called as Witness:* The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

   It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

PAYMENT FOR MEDICAL SERVICES RENDERED

Upon final disposition of any case wherein services rendered by a physician are involved, the lawyer shall forthwith notify the physician of such disposition and upon the receipt of the physician's bill and an order from the patient to pay the same direct to the physician, the attorney shall use every reasonable effort to see that the physician's bill is paid forthwith. The attorney shall make no charge to the physician for any services rendered in connection therewith. Unless otherwise agreed, the primary responsibility for payment of medical expenses rests with the client-patient.

COMMITTEE ON INTERPROFESSIONAL RELATIONSHIPS

For many years the Medical and Chirurgical Faculty of the State of Maryland and the Maryland State and City of Baltimore Bar Associations, recognizing the need of a committee composed of both physicians and lawyers for the purpose of promoting a closer and more harmonious relationship between the two professions, have designated annually a group of physicians, now (12) twelve, to work with a corresponding number of lawyers (agreed upon and appointed jointly by the two Bar Associations).

The subcommittee on interprofessional relations of the said Joint Committee of 24, which subcommittee is composed of 4 physicians and 4 lawyers, who shall be designated by the chairmen of the respective groups and shall annually select its own chairman alternately from the medical members and the legal members; it shall consider all matters concerning interprofessional relationships between these two professions, including but not limited to the following:

1. Promotion and perpetuation of harmony between the professions.
2. Achieving a fuller understanding of mutual problems.
3. Consideration of legislation affecting medical-legal professional relationships.
4. Hearing of grievances stemming from interprofessional relationships.
5. Referral of grievances to the Medical and Chirurgical Faculty of the State of Maryland or the Bar Association concerned where that committee deems such reference warranted.

PHYSICIAN/PATIENT RELATIONSHIP

The legal profession recognizes that the practice of medicine is a hazardous task and that it is obviously not always possible for the physician to obtain a good result even with the best of attention and professional skill, and that an unfortunate result does not indicate in itself that the physician did not exercise the highest degree of skill and attention in the treatment of the case; and that a lawyer should not undertake to make any claim against a physician without thoroughly investigating the essential facts and details and being reasonably certain that if a harm has been done a patient, that it was due to genuine carelessness or negligence or lack of professional skill as distinguished from honest difference of opinion or the difference in honest judgment in a particular case. It should, nevertheless, also be considered that by the Canons of Professional Ethics the lawyer owes devotion to the interest of his client, warm zeal in the maintenance and defense of his rights, and the exertion of his utmost learning and ability, and that the client is entitled to the benefit of any and every remedy and defense that is authorized by law, and he may expect his lawyer to exert every such remedy or defense.

The medical profession recognizes that there are cases in which the patient suffers injury as a result of negligence, carelessness, or lack of professional skill on the part of a physician and that in these cases, there should be just compensation to the injured person. That in cases of this character, it is as much the duty of a physician-expert to assist the injured person as it is the duty of a physician-expert to defend a fellow-physician when he is proceeded against improperly.

GENERAL PROVISIONS

Nothing contained in this Statement of Principles is intended to be inconsistent with the rules of law, Canons of Ethics of the local, state and national Bar Associations and the Principles of Medical Ethics of the American Medical Association.

Respectfully submitted,
HOWARD F. KINNAMON, MD, Chairman
CONRAD ACTON, MD

James G. Arnold, Jr., MD
Everett S. Diggs, MD
E. W. Ditto, Jr., MD
Russell S. Fisher, MD
William E. Grose, MD
Robert W. Johnson, III, MD
Amos R. Koontz, MD
J. Elliot Levi, MD
F. Ford Loker, MD
Belden R. Reap, MD
Edwin Ruzicka, MD
William G. Speed, III, MD

SUBCOMMITTEE ON SYMPOSIA MANAGEMENT: James G. Arnold, Jr., MD, Everett S. Diggs, MD, William E. Grose, MD, J. Elliot Levi, MD, Edwin Ruzicka, MD.

SUBCOMMITTEE ON INTERPROFESSIONAL RELATIONS: Russell S. Fisher, MD, Robert W. Johnson, III, MD, Belden R. Reap, MD, William G. Speed, III, MD.

SUBCOMMITTEE ON COURT PROCEDURES: Conrad Acton, MD, E. W. Ditto, Jr., MD, Amos R. Koontz, MD, R. Carmichael Tilghman, MD.

SUBCOMMITTEE TO DEVELOP A PROFESSIONAL CODE GOVERNING THE RELATIONSHIP BETWEEN DOCTORS AND LAWYERS: Sol C. Berenholz, Esq., chairman; Calvin E. Cohen, Esq., Russell S. Fisher, MD, Howard F. Kinnamon, MD, Belden R. Reap, MD.

SUBCOMMITTEE FOR THE PURPOSE OF DEVELOPING GUIDELINES FOR THE FUTURE OPERATION AND ORGANIZATION OF THE MEDICOLEGAL COMMITTEE: Howard F. Kinnamon, MD, Conrad Acton, MD, J. Elliot Levi, MD, William G. Speed, III, MD.

PROFESSIONAL FEE FUND COMMITTEE

Mr. President and Members of the House of Delegates:

In May, 1963, the House of Delegates adopted Resolution 9A/63, dealing with the Corporate Practice of Medicine by Baltimore City Hospitals. This resolution also considered other areas such as the denial to the patient of the choice of his own physician because of the "closed" staff at City Hospitals, the fact that no active medical practitioners are on the so-called "Advisory Board" of City Hospitals, and that such representation be urged by the Faculty.

Your committee has had several meetings to discuss this and other related problems. We have found it extremely difficult to obtain meaningful statistical data on the number of house staff that are actually used in the various services at City Hospitals. We believe, however, that this phase of the problem is not particularly germane to the matter at issue.

The Professional Fee Fund Committee makes the following recommendation to the House of Delegates:

Since the Medical Practice Act of the State of Maryland would appear to define the Corporate Practice of Medicine as illegal, since the actions of the House of Delegates of the AMA quite clearly condemn the Corporate Practice of Medicine by Hospitals, since we are informed that this practice may be spreading into the counties as well as Baltimore City, and in the light of the decision of the Court of Appeals of Maryland as reported in The Daily Record, March 24, 1964, regarding the Corporate Practice of Funeral Directors, the Professional Fee Fund Committee is of the opinion that immediate steps should be taken to ascertain the legality, or otherwise, of Corporate Practice of Medicine in Maryland, if necessary by court action; and

All physicians in Maryland who are members of the Faculty be advised they must comply with the following Principles of Medical Ethics as established by the American Medical Association and failure to do this will result in charges being brought against them for unethical conduct through the mechanisms provided in the Faculty Bylaws and the Medical Practice Act of Maryland:*

RELATION OF PHYSICIANS AND HOSPITALS

A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research for charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine. *(House of Delegates, 1951; reaffirmed, House of Delegates, 1963 and 1964)*

Respectfully submitted,
William B. Settle, MD, Chairman
William H. Mosberg, MD, Vice-chairman
Harry J. Connolly, MD
George O. Eaton, MD
Theodore Kardash, MD
Harry M. Robinson, Jr., MD
Richard W. TeLinde, MD
John F. Schaefer, MD

*Adopted, see minutes.

N.B. The Reference Committee made no report, as no resolutions had been submitted by the deadline established in the Bylaws.

SPECIAL MEETING
February 20, 1965

MINUTES

The 248th meeting, Special Session, of the House of Delegates of the Medical and Chirurgical Faculty, was called to order at 2:15 PM, Saturday, February 20, 1965, at the Faculty Building, Baltimore, Maryland, the President being present.

Dr. Ebeling was, by general consent, selected to serve as Secretary Pro Tem in the absence of Dr. Pillsbury.

The following delegates (or alternates) were registered as being in attendance. An asterisk indicates an alternate delegate.

Doctors: *Robert T. Adkins, Wicomico County; John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Harry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Council, Past President; Robert vL. Campbell, Council; *Robert G. Chambers, Baltimore City; *Katherine A. Chapman, Montgomery County; Stuart Christhilf, Anne Arundel County; Archie R. Cohen, Washington County; *H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Baltimore City; Merrill M. Cross, Montgomery County; William B. Culwell, Carroll County; *Charles H. Doeller, Jr., Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; Louis C. Dobihal, Baltimore City; J. Sheldon Eastland, Council, Past President; William C. Ebeling, Council; *Max R. English, Baltimore City; *Robert E. Ensor, Baltimore City; Robert W. Farr, Council; James McC. Finney, Harford County; Whitmer B. Firor, Past President; Russell S. Fisher, Council; Albert E. Goldstein, Council; Edward G. Grau, Baltimore County; Oskar Gulbrandsen, Kent County; William B. Hagan, Council; Thurston Harrison, Council; John C. Harvey, Baltimore City; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; *Claude D. Hill, Baltimore City; William A. Holbrook, Prince George's County; James R. Karns, Baltimore City; Louis F. Klimes, Baltimore City; Louis Krause, Council; Herbert H. Leighton, Garrett County; Charles Ligon, Montgomery County; Charles R. MacDonald, Anne Arundel County; Howard B. Mays, Council; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald Mintzer, Baltimore City; Frank K. Morris, Board of Medical Examiners; George A. Moulton, Jr., Carroll County; Richard Norment, III, Council; Charles F. O'Donnell, Council, Past President; Jonas R. Rappeport, Baltimore County; C. G. Rawley, Somerset County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Paul F. Richardson, Baltimore City; Eugene J. Riley, Baltimore City; Raymond C. V. Robinson, Baltimore City; Austin R. Rohrbaugh, Jr., Council; Donald J. Roop, Council; *Peter A. Santucci, Montgomery County; Emmanuel Schimunek, Baltimore City; William B. Settle, Baltimore City; James E. Stoner, Jr., Frederick County; E. L. Suarez-Murias, Baltimore City; F. J. Townsend, Jr., Worcester County; Aaron H. Traum, Montgomery County; Robert S. Turner, Jr., Frederick County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Lawrence R. Wharton, Jr., Baltimore City; J. Arthur Weinberg, Council; *Ralph H. Williams, Washington County; Hans Wodak, Prince George's County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; Israel Zeligman, Baltimore City; Walter N. Kirkman.

Present also for the meeting were staff personnel, as well as Donovan F. Ward, MD, President of the American Medical Association and invited guests.

RESOLUTION ADOPTED AS AMENDED

After presentation of prepared remarks by Drs. Goldstein President), Donovan F. Ward,† B. Martin Middleton (Legislative Chairman), and Raymond M. Yow (Public Relations Chairman), followed by general debate, the following resolutions were adopted as amended:

> *Resolved,* That in accordance with Article III, Section 6, of the Bylaws, an assessment be imposed in the amount of $50.00, to be paid, in addition to dues, by all active members except those in the first and second years of private practice.
>
> *Resolved,* That said assessment shall be due and payable upon the adoption of these Resolutions.
>
> *Resolved,* That members of the Faculty, other than active members to which these Resolutions apply, shall be invited to make a voluntary contribution to the Faculty to be applied to the purposes for which this assessment is levied.
>
> *Resolved,* That all sums of money raised in this manner be utilized solely for continuing educational purposes related to public and professional education in connection with health care programs, health care for the public, and to continue relating the story of American medicine to the public.

The President, by unanimous consent, declared the House adjourned *sine die,* at 4:30 PM.

Respectfully submitted,
WILLIAM CARL EBELING, MD, *Secretary Pro Tem*

†As corrected by House of Delegates, April 21, 1965.

REMARKS BY ALBERT E. GOLDSTEIN, MD

Gentlemen: It has become a cliche these days, whenever there is evidence that there are rumblings in the internal organs of American medicine, to quote the old saying, "Physician, heal thyself."

I shall not perpetuate the cliche.

This House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland—125 delegates representing some 3,000 physicians—is gathered in this hall, named for Sir William Osler, who brought to Maryland and American medicine a new concept in healing, not to heal ourselves. We are concerned with the whole state of well-being of those whom we call our elders. American medicine has made it possible for more and more of its citizenry to live longer. Having accomplished this, we are equally concerned that the medical care offered them shall not be a misnomer: a health plan which includes no medical care. We are here to call a spade a spade, or to call the care of our elders

Eldercare rather than that deceptive Medicare, which is governmental gobbledygook for very little care at all.

In 1848, the very first national meeting of the American Medical Association was held in Baltimore. This 20th day of February, 1965, by what we do here we too may be setting a precedent worthy of Maryland's place in medical history.

If you gentlemen approve the resolution being placed before you to approve an assessment to conduct an educational program on what should comprise honest, decent, and completely adequate health care for those of our citizens who reach 65 years of age, we shall be facing up to our responsibilities.

Education on what such a health plan can be is necessary not just for the so-called lay public. But you, too, and all the members of the medical profession need to know what Eldercare can provide and what Medicare does not offer.

It is time to check pulse and temperature of the body politic of American medicine, gentlemen.

ADDRESS BY DONOVAN F. WARD, MD, PRESIDENT, AMERICAN MEDICAL ASSOCIATION

When the American Medical Association was born in the middle of the last century, it had a mission: "to promote the art and science of medicine and the betterment of public health." And it must be a matter of the most solemn pride to all of us that we can say here today: We have carried out that mission, and carried it out beyond the fondest aspirations of our forebears.

American medicine is recognized as the finest in the world. The American system of health care is the wonder and the envy of people everywhere.

We know this progress is no mere accident of history; no automatic product of this or any other age; no casual blending of chance and the passage of the years. Rather, it is a living, enduring tribute to the genius and determination of thousands of men and women who have succeeded, shall we say, where the medieval alchemists failed. In an atmosphere of freedom, these dedicated members of the health team have grasped the opportunity to transmute hopes and dreams and ideas into a reality more precious to mankind than the earth's entire storehouse of gold. They have prolonged life, overcome sickness and pain, and strengthened the nation by adding years to the productive life-span of our people.

They have been free to work, to think, to match their talents against the best found anywhere else on earth, unhampered by outside interference, unfettered by government controls. Indeed, progress and freedom are rooted together. But ours, we have learned, is an unending crusade. Today the free institution of medicine is challenged as never before. Our mission remains the same as it has been for 147 years: "to promote the art and science of medicine and the betterment of public health." We intend to go on fulfilling that responsibility and carrying out that mission.

When I addressed the AMA House of Delegates last November, I said, and I say again: "Now we are the trustees of our profession's noble heritage. We have no choice except to stand firm in our efforts to prevent these standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

This is the task for which we have been tapped by destiny's fingertip and the combination of circumstances as we find them at this midpoint in the 20th Century. It has fallen to us to stand in the vanguard of an historic struggle for principle. There, keeping faith with yesterday, today, and tomorrow, we have been holding fast for years, turning back successive assaults on the institution which we represent. The long-fought engagement now has entered its climactic stage. The next few weeks will undoubtedly determine the outcome.

Far from being filled with consternation over the prospect, we have every reason to move forward into the renewed fray with our heads erect and our spirits high. It has taken courage and heart and a jaunty nerve to face down the tremendous power that has been turned on us before—by the government, by the leaders of organized labor, and by the restless propaganda arms which have been organized and subsidized to promote federal intervention in the field of medicine. Yet we have never wavered in our trust that right and justice would triumph in the end.

I salute you and every member of the society which you represent for the strength of purpose and the fortitude which has marked your conduct over this long period of stress.

If now I must call on you again for even greater efforts, it is only because I know you are aware of the crucial nature of the weeks that lie ahead. I am confident that you and your colleagues are prepared, each of you, to contribute something of yourselves to this cause which is so important to the future well-being of all Americans.

We have as individuals and as a profession drunk deeply from the cup of liberty. Its blessings have had a clear and lasting meaning for us, permitting us to know as few others do the inner satisfaction of helping and serving our fellow humans. Now, we are called upon to march forth to fight the good fight for basic moral principles on which the institution of freedom rests. Now it is our turn to join those in other generations on whom this charge has fallen.

Make no mistake about it, this is not simply a conflict over whether government should tax one group of citizens to provide health benefits indiscriminately, regardless of need, to another group. This is not solely a disagreement over the best means of providing health care for our elderly citizens. If that were the only issue there would be no question about the adoption of the Herlong-Curtis Eldercare Bill, which closely follows the recommendations of the medical profession. This legislation would assure every American the medical care he needs—complete care—in his retirement years. It would be soundly administered and financed. It would bring into the program the knowledge and years of experience of the established insurance system. It would preserve medical freedom while avoiding the necessity for the creation of a costly, new federal bureaucracy to take over the spending of the people's money from the people themselves.

There is simply no comparison between the virtues of this measure—the greater benefits for those who truly need help, the less overall cost to taxpayers, the freedom from government regulation and control—and the narrow terms of the compulsory tax program which has been sold to millions of Americans under the false name of Medicare.

No, this is not the entire issue. Rather, this controversy touches on questions far more grave, more important to the American people than health care for the aged—which everybody agrees they shall have regardless of ability to pay for it. There never has been any difference of opinion on that point.

It is true, this battle is being fought to safeguard a progressive and dynamic system of medicine from being dragged under the yoke of centralized federal domination, eroding the patients' freedom of choice and the physicians' freedom of practice. But even more, it is being waged in realization that if the freedom of medicine falls, other freedoms will follow.

History has shown repeatedly and continually that individual freedom is the essence of liberty; that as an individual loses his identity, surrenders his dignity and his authority over his own concerns, liberty dies.

The foundations of our Republic were built on an escape from tyranny. Let me remind my fellow Americans that we as a people must be careful we do not lose the foundation as we pursue the mirages of *escape from risk, relief from toil, release from responsibility* under an all-encompassing government benevolence.

Often, as I have reflected on the present course of events in this land of ours, I have wondered how the historians of some future era will view the strange paradoxes of our time. As they turn the pages of the record which this generation is writing, they will note that this was a period when virtually all of mankind was caught up in a surge toward freedom without parallel in human history.

At the same time, it cannot escape their attention that here in the United States there has been a growing acceptance of—and submission to—the influence of central government power over the lives and activities of our citizens. We have every reason, I believe, to be concerned that we are fast reaching a point where, in our complacency and our calm acceptance of our heritage as some kind of an indestructible, inalienable right, we are in danger of letting American freedom slip away lightly between our fingers.

A glance across the Atlantic to Western Europe should be sufficient to show even the most doubting how government can devour the substance of a self-supporting people to make them self-supporting no longer, and to establish a condition of universal reliance upon the paternalism of a bureaucratic elite.

We know we have developed the finest system of health care in the world. But the nation is considering drastically altering that system and starting it down the same road that has been traveled by other countries whose health care today is marked by turmoil, bureaucratic controls, overburdened facilities, and harassed, frustrated doctors.

Why? Because powerful forces in and out of the government see the proposal to federalize hospital and related health care for the nation's aged as a logical extension of social welfare in this country. They are determined to get this law on the books. Then it can be expanded without limit to bring everyone under a system of government medicine in the United States. It is merely part of the grand design which is to change or overturn our free society.

This is the historic issue that lies at the heart of the violent controversy into which we have been plunged. We are fighting for our profession, but we are serving a higher purpose. We are fighting for liberty.

It is no mean commission we have been handed. All Americans, whether they realize it or not, have a vital interest in the success or failure of our efforts. Future generations will be affected by the outcome for a great many years—in the quality of their health care, in their basic freedoms, in their tax burdens to support their government.

The hour is late. The stakes are high. This sure knowledge should spur us to launch and to drive forward with the most intensive educational program humanly possible.

Each physician in the United States must tell and retell to his patients, his friends, and everyone within the sound of his voice the story of the new, expanded health care program for the elderly which has found expression in the Herlong-Curtis Eldercare Bill. And he must tell it by way of every conceivable communications medium.

As the elected representatives of your state medical society, it is incumbent on each of you to accept the responsibilities of leadership in this campaign, not as a burdensome duty but as an obligation of mature men devoted to their country and the integrity of their profession.

It is imperative that we act at once and on a scale never before approached. If we do, a floodtide of protest over the proposed federal program will reach Washington that simply cannot be ignored.

But I must emphasize this is our last chance. If Medicare passes, there is no turning back. It cannot be tried and then be put aside for something else. It will be a permanent departure from our fundamental American way.

This, as I have tried to show, is everyone's fight. But it has become ours. We did not ask for it. We do not like it. But let us fight it. Let us fight with all that is in us. And may reason and justice prevail across the land.

REMARKS BY B. MARTIN MIDDLETON, MD

Dr. Goldstein, Dr. Ward, Officers of Med-Chi, and Fellow Delegates: Let the AMA do it! Let our officers do it! Let the Executive Secretary do it! Medicare is inevitable; we doctors should accept it and work out the best deal we can get! How often have each of you heard these remarks? Well, gentlemen, the time has come for us to realize that *we* must do it; that *we* must speak up and tell the story of medicine. We must reaffirm to the citizens of Maryland that we are determined to provide the highest quality of medical care possible. We must assure our citizens that we support proper legislation geared to the needs of this state. We support the concept that all should receive comprehensive medical care to the extent of need, regardless of ability to pay.

In September of 1964, I reported to this House of Delegates on our current status and began the first of a series of information programs. Much has happened since this time. The congressional make-up has changed; a renewed campaign to force government controlled medicine upon our land has begun. Much study and resultant positive programs have been formulated by the AMA Maryland has been well represented at conferences designed to meet the medical needs of today and the future, and we shall continue to recommend changes as time passes.

The single greatest problem that I see today is the depression and apathy of many physicians. The reason for this is equally clear—*lack of communication.* A recent Gallup poll revealed that 77% of Americans either had no information or misinformation concerning medical legislation, specifically, the King-Anderson Bill. I am confident that nearly the same ratio is true for physicians. Most physicians do not know that persons 65 and over comprise 90% of our total population and control 8% of our wealth; most do not realize that this age group is the fastest growing economic group in America; over 130% in the past 10 years as compared to 80% in the

below 65 age group. Most physicians do not realize that under any payroll tax, 40% of income will not be taxed; that the young workers of America, least able to pay, will be taxed to provide medical care for *millions* of Americans perfectly capable of caring for *themselves*. Yes, most doctors do not realize that a utilization review committee, under the King-Anderson Bill, has the authority to determine medical necessity for their patient and that funds could be withheld by the government on the basis of the committee report.

Physicians and the public must be made aware of the AMA supported Eldercare Plan. This plan provides comprehensive care to persons 65 and over who need such help. The means test has been eliminated with benefits available on a simple statement of income. There will be maximum and minimum income limits set by the states, with those below the minimum paying no premium; those between would pay a partial premium, on a sliding scale. Those above the maximum income limits would receive an income tax benefit for noncompensated medical expenses. The program would be financed by federal state funds under existing programs.

Your Legislative Committee feels strongly the need for improved communication among all the doctors of this state. To this end we have sought the aid of the Public Relations Committee, and Dr. Yow will present the details of this joint program. We feel that regardless of the outcome of the present proposed federal legislation, a sound, long-range program of communication is needed. The doctors of our society must be kept more adequately informed of all phases of this society's activities and participate more actively in major decisions.

Unfortunately, such a program would cost large sums of money. This society must recognize that need. We are asking you to rate a special assessment on the membership of $50.

I shall again report to you at the April meeting with additional ideas to implement the long-range programs designed to assure that members of the Medical and Chirurgical Faculty will be the best informed doctors in this land.

REMARKS BY RAYMOND YOW, MD

Introductions and salutations: Before giving specific recommendations for a public relations program, I should like to take a moment to define public relations and bring this subject into its proper perspective.

To begin with, I wish I could come up with a better name, for our activities include public relations as only one of the many-sided, total picture. Our mission includes membership education, public education, speech training, medical careers recruitment, and many other facets. Legislative and news media relations are also our concern. Indeed, public relations is more than buying an ad in the newspaper or enticing a colleague to appear before a local television audience. So, for our purpose, we shall consider a public relations program as a planned, organized, sustained program of communication and education aimed at both the members of the Medical and Chirurgical Faculty and the public which it serves.

In a few moments I shall outline for you a proposal for such a program for the Faculty. In order to better acquaint you with the overall picture, may I point out that many state societies and many large component societies have programs of this type in effect. California, with some 23,000 physicians, budgets $150,000 annually for public relations. Illinois budgets $75,000. Connecticut budgets $35-40,000. These figures were for late 1963, when I presented this same problem before the Council of the Medical and Chirurgical Faculty. They may be low, for nothing has made these programs any cheaper. Those areas that have a developed and budgeted program have been pleased and feel that the values received for the dollars spent have been well worthwhile.

In Maryland, our geographical problems are no greater than any other state, yet it is a far ride from the Eastern Shore to Allegany County. Many of our component societies are small, some are large, and many are medium sized. Many are hampered by membership apathy. My proposal will overcome many of these problems. Some of our members feel that it is too late to worry about public relations. I cannot agree. Regardless of what happens in Congress in the next few weeks, we will need a good and sustained public relations program. I might add at this point that had we been stronger with our public relations at all levels, and especially at the local level, years ago, we might not now be waging a battle for Eldercare. American business long ago recognized the need for public relations, and today businesses, both large and small, have such executives on their payroll. I do not believe that American business would tolerate such expense if it did not feel it was beneficial to their cause.

With these brief remarks as background, I hereby submit the following proposals for your consideration.

1. That a budgetary item for the purpose of public relations be included in the operations of the Medical and Chirurgical Faculty.
2. That this budget be used in the following manner or purposes:
   a. Full time executive be retained to serve under the Executive Secretary for the purpose of developing, implementing, and sustaining a full time public relations program. Ancillary duties could include legislative activities as well as some administrative tasks of the Medical and Chirurgical Faculty office. Over 20 state societies have such an officer on their payroll. North Dakota, with only 400 members, has had such a person for several years. This executive would be expected to maintain close and active liaison with all component societies. He would be charged with the elimination of the apathy of many of our colleagues and assisting in the implementation of component society programs. Because of the nature of his work, adequate expense allowances for travel and administration should be planned.
   b. Retain professional public relations consultant when needed, on a per diem basis. Until an executive can be obtained, use of professional public relation agents on a continuing basis is recommended.
   c. Increased efforts to educate the Medical and Chirurgical Faculty membership.
   d. In order to stimulate membership interest in the various state and AMA programs, attendance of selective key members to AMA conferences, such as the AMA Institute, should be subsidized to some extent by the Medical Faculty.
   e. Increased activity in the field of health careers and medical recruitment.
   f. Correlation of public relations and legislative

continued on page 70



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References: 1. Carpenter, E. B., South. M.J. 51:627, 1958. 2. Crookshank, J. W.: J. Louisiana State Med. Soc. 114:272, 1962. 3. Feinberg, I., et al.: Am. J. Orthoped. 4:280, 1962. 4. Fitzgerald, W. J.: Miss. Valley M.J. 82:146, 1960. 5. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 6. Meyers, G. B., and Urbach, J. R.: Penna. M.J. 64:876, 1961. 7. Truitt, E. B., Jr., Morgan, A. M., and Nachman, H. M.: South. M.J. 54:318, 1961. 8. Weiss, M., and Weiss, S.: J. Am. Osteopath. Assn. 62:142, 1962.

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activity by combining both committees, as many of their problems are interrelated.

g. Activate and aggressively implement a speakers bureau in every county society, filling in on a state level basis if the county is not able to set up a speakers bureau.

I should like to emphasize that I envision the whole plan as beginning at the component society level. The state level serves as a source of ideas, stimulus, and how-to-get-the-job-done know-how. While a PR executive cannot do our job for us, he can materially aid us. But without an enthusiastic membership he can do little. A PR executive cannot do for us what we are not willing to do for ourselves.

I am aware of the apathy, disinterest, and total lack of concern by many of our colleagues. But may I remind you that the heritage of the Med-Chi is great. We are one of the oldest societies in the country, and we point with pride that our past presidents have included such names as Osler, Halsted, Welch, and Young.

I know not what your decision today will be. I do know that we cannot stand still. We must go forward with determined steps. Decisions for increased activity will cost money. I estimate my proposal will initially run $25,000 and can foresee a steady increase to at least $50,000 a year. A decision in the opposite direction will only cost us our heritage and our freedom. The decision is yours.



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COMPONENT MEDICAL SOCIETIES

BALTIMORE COUNTY

On May 19, St. Agnes Hospital was host to the Baltimore County Medical Association for its regular monthly meeting. The occasion was highlighted by a demonstration of the Medical Hotline, which in this instance featured an interview with **Henry C. Scruggs, MD,** consultant in endocrinology at St. Agnes Hospital and instructor in medicine at the Georgetown University School of Medicine. Dr. Scruggs discussed renal biopsies, in response to questions from the moderator and members of the audience through a special hookup with Washington, DC.

The business meeting was called to order by the president, **John Snyder, MD. Angelo D'Agostino's** application for membership was approved. A letter was received from Strudwick Associates announcing that the company is now able to carry our insurance itself rather than placing it with another company. Strudwick Associates would like the Association to transfer insurance to them. Since the Medical and Chirurgical Faculty and the Baltimore City Medical Society have this plan and there was no objection from the members, this will be done.

William Pillsbury, MD, chairman of the Nominating Committee, read the slate of nominees:

President: **Edward L. Krieg, MD**

Vice president: **Edward Gordon Grau, MD**

Secretary-treasurer: **Sidney Johnson Venable, Jr., MD**

Delegates:

John Snyder, MD

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Donald Wood, MD
Martin Strobel, MD
Charles H. Williams, MD

Alternates:
Kent Robinson, MD
Henry McCorkle, MD
Theodore Patterson, MD
Robert Ensor, MD
John Darrell, MD

State Nominating Committee: **Edward L. Krieg, MD**

Representative to the Policy and Planning Committee: **John Hyle, MD**

The June meeting, which is the election of officers and annual business meeting was held at the Penn Hotel in Towson. The wives were invited to attend the luncheon and meeting. The Woman's Auxiliary will present a nursing scholarship at that time.

The annual crab feast will be held at Duffy's Restaurant on August 18. Members will be guests of the Association, and any guests of members will pay a fee.

Dr. Roop, chairman of the Liaison Committee, reported on a meeting that was held recently to discuss an allergy study being conducted at Johns Hopkins Hospital. **Marie Rhyne, MD,** director of allergy in the Department of Pediatrics at the Johns Hopkins Hospital wanted to circularize the parents of the children in the Catonsville area who have not responded to ragweed vaccines. This study is a request of the FDA to try to regulate the dosage of ragweed vaccines. The Board of Governors approved this request.

Charles H. Williams, MD



WICOMICO COUNTY

MEDICAL SERVICES AT CHICKEN FESTIVAL

A first aid station and free tetanus toxoid program were set up for the annual Delmarva Chicken Festival, by the Wicomico County Medical Society, Inc.

Request for this project was made by the management of the Festival, which was held in Salisbury at the Wicomico Youth and Civic Center, June 17-19. Some 30,000 visitors attend the three-state Festival each year, which features a chicken-cooking contest attracting entrants from all 50 states.

A physician and a registered nurse were on duty at all times for first aid and to administer the vaccine. Members of the Nurses Alumni Association of the Peninsula General Hospital School of Nursing cooperated with the medical society in providing this coverage.

COMMUNISM DISCUSSED AT MAY MEETING

"Communism" was the topic of the guest speaker for the May meeting of the Wicomico County Medical Society, the **Rev. Charles Paris.** Guests at this meeting included **Denwood Kelly,** Blue Shield executive; **Richard Nelson,** AMA field representative; and **Forest C. Thompson** and **Virginia Layfield,** administrator and assistant administrator of the Peninsula General Hospital, Salisbury. Several wives of members also attended to hear the speaker. This was the last meeting of the medical society until September.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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PRESERVATION OF MEDICAL EVIDENCE

JOHN E. ADAMS, MD

THE LOSS OF MEDICAL AND SURGICAL specimens of medical-legal value is a common problem at the medical examiner's office. This loss, often irreparable, apparently is caused by the attending physician's failure to recognize the importance of the tissue or fluid removed before death. Particularly common is the situation after a gunshot wound of the head, in which there is a sufficient survival period to allow surgical treatment. The entrance and exit wounds, as well as muscle and dura in the margins of the wounds, are excised and distorted or discarded altogether. Such a patient dies and is brought to the medical examiner's office for autopsy, at which time it is found that all evidence to establish the manner in which the wound was inflicted (accident, suicide, or homicide) has been removed.

If the properly labeled surgical specimens cannot be recovered, the medical examiner has no way to establish the manner of death from medical evidence. He must then rely solely on the circumstances surrounding the incident without benefit of corroborative physical evidence from the body. In such a case, determination of the manner of death, often a difficult task under the best conditions, must then be made on inconclusive or insufficient evidence, if it can be made at all.

The pathologist uses many criteria for determining the manner of death in gunshot wounds. Important among them are the presence or absence of powder in the wound and gunbarrel contusions in the wound margins in order to determine range. Without entrance and exit wounds, it is impossible to determine range with any accuracy; hence the manner of death may be uncertain. Often the direction of the missile traveled is misinterpreted in through and through wounds, since approximately 50% of skin wounds caused by missiles are atypical, requiring an experienced observer for accurate interpretation. The surgeon's description of the wounds is usually not sufficient to answer the questions of forensic importance, because he is not aware of the necessary observations. In through and through wounds of the skull, craniotomy performed through both skull wounds effectively destroys the evidence to determine the direction of travel through bone; furthermore, without the skin wounds, the pathologist cannot even tell from which direction the bullet came. It is, therefore, extremely important when the skin wounds from any location are excised, that they be excised with wide margins and preserved *intact* for the medical examiner, who will call for them in the event of the patient's death. Equally important, they should be labeled as to anatomic source rather than with interpretative labels of "entrance" or "exit."

Bullets or other penetrating objects removed at surgery should be kept in the immediate custody of the person removing them until a police representative calls for them. Preservation of the chain of custody requires that the surgeon deliver the missile directly to the police and that he obtain a receipt for it to document transfer of the evidence. It is also important to note accurately in the patient's chart the position of the missile in the body when removed, rather than to rely on memory alone to produce such facts a year or more later when the case may come to adjudication. The course of the missile in relation to the three body planes is also important. If the victim survives, the surgeon's notations and description of the penetrating injuries, from which the course of the missile and the range may be determined, are major criteria for establishing in court the true motive and manner.

A case seen recently at the medical examiner's office graphically illustrates these points. A woman shot and killed her husband and then shot herself in order to divert suspicion. She told the police that a burglar had shot her husband and then shot her in the back as she was attempting to

escape. The physicians accepted her story as compatible with the injuries and excised the skin wounds in the abdomen and in the back. Not until the forensic pathologist examined the skin wounds did it become apparent that the woman was lying, for the direction of the shot had been misinterpreted as posterior to anterior, whereas the entrance wound was actually in the abdomen and apparently self-inflicted. Confronted with this evidence, the woman admitted that she shot her husband and then herself.

Stab wounds are not often excised; when they are, they should be preserved in the same manner as described for gunshot wounds. By the time the body reaches the morgue, the wound may have partially healed or may be included in an extensive surgical incision and destroyed as valuable medical evidence. The characteristics of the skin wound are of great value in providing a description of the probable weapon. When more than one weapon is involved, these characteristics may enable the examiner to choose between weapons and to implicate one person as the probable assailant. The surgeon should make an effort to observe the important features of the stab wound before extending or suturing it; important observations to be recorded are its length, the quality of its margins (sharp or with marginal abrasion), and the character of its angles or ends (sharp and symmetrical or dull and irregular). With this information, a stiletto wound may be distinguished from a wound made by a penknife or screwdriver.

Body fluid specimens often are of similar critical importance in documenting the cause and manner of death. Gastric lavage specimens, especially the first aspiration and washing, should be retained until the patient recovers or succumbs. This is essential because substances such as chlorinated hydrocarbons, phosphorus, and organic phosphates are no longer detectable in blood or body tissue with survival for more than 24 to 48 hours. Quantitation of barbiturate in stomach contents may enable one to distinguish between an accidental and a suicidal ingestion, with or without survival. When a medical-legal death occurs which is related to metabolic dysfunction, such as electrolyte imbalance or hyperglycemia, leaving no anatomic evidence for the prosector (phenothiazine side effect death, for example), it is essential to retain refrigerated blood and serum samples until they are called for. The smallest postmortem interval destroys the value of blood obtained at autopsy for potassium and glucose determination, abnormalities of which may be the only evidence to explain the death.

It is surprising that not more samples for blood alcohol determination are obtained antemortem. Determining the blood alcohol level is justified if it is needed for evaluation of the patient's state of cerebration and to distinguish, for example, the effect of alcohol from the effects of trauma. With survival for more than 12 hours and/or the use of multiple transfusions of blood and plasma expanders, information as to the presence and degree of alcoholic intoxication on admission is lost. Such information, which may work for or against the injured party, can be extremely important in subsequent adjudication. A negative blood alcohol in an industrial accident involving a person with a previous drinking history can be the single most important rebuttal of the defendant's claim of contributory negligence. Conversely, a significant blood alcohol level in a driver involved in a two-car collision may help to affix responsibility where it should be and relieve the guiltless of responsibility. It would seem appropriate to at least draw, refrigerate, and store the blood sample and let the chips fall where they may in the interest of truth. The sample should consist of 10-15 ml of oxalated blood in a carefully labeled and tightly stoppered container.

It is not the intention of the medical examiner to ask the physician to alter his treatment of the injured person in any way for the benefit of forensic science. The medical examiner simply asks that the attending physician realize the problems involved and, when convenient, take appropriate steps to preserve and record observations, specimens, and wounds which may be of great forensic value. In treating a case with obvious or potential medical-legal implications, the physician should not forget that he has an important obligation not only to his patient but also to his patient's family and to the other parties involved in the incident. The medical-legal responsibility of the physician without limiting his procedure is to preserve the evidence thoughtfully, diligently, and completely by attempting to anticipate questions which might arise in the future. The physician's zeal in preserving the evidence, whether the patient lives or dies, can be critical in the subsequent process of seeking out the true circumstances of the incident and will help to obtain justice for all concerned.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

RECENT ADVANCES IN THE REHABILITATION OF RHEUMATOID ARTHRITIS

RHEUMATOID ARTHRITIS IS A CHRONIC, physically disabling disease. Its course is punctuated by painful exacerbations, frequently leading to severe deformity and dependence. It may affect the patient's will, motivation, and emotional attitudes and cause depression and anxiety. As a consequence of this constellation of misery, the patient's family, home, finances, and vocation may suffer deterioration.

Because of its chronic nature, its involvement of physical, emotional, and social areas, rheumatoid arthritis requires a comprehensive approach.

* * * * *

The remarkable interest in the diseases of connective tissues started in the early 1940's with the work of the pathologists. Klemperer in disseminated lupus erythematosis in 1941 and Rich in hypersensitivity and periarteritis nodosa set the stage for the intense clinical interest. The discovery of the LE phenomena by Hargraves and the sheep cell agglutination reaction by Rose spurred further investigation. Hench's use of steroids in rheumatoid arthritis stirred the imagination of the medical community. It appeared at first that rheumatoid arthritis was really "reversible," as Hench indicated in his report. Later studies showed that the progression of the disease was not arrested by the use of steroids. The stimulus to new research may be a more important consequence of the discovery of the steroids than their effect on disease.

There has been a less dramatic growth in the clinical management of rheumatoid arthritis. Nevertheless, some of these advances are important.

* * * * *

In the coming months recent developments in diagnosis and treatment of rheumatoid arthritis will be reviewed briefly in these notes.

Some of the areas to be reviewed are:

1. Evaluation of patients with rheumatoid arthritis.
2. Advances in the immunologic aspects of rheumatoid arthritis over the past few years which have added to the understanding, precision of diagnosis and prognosis.
3. Evaluation of various drugs in rheumatoid arthritis and indications for their use.
4. Use of physical modalities with balanced rest and exercise.
5. Orthopedic surgery in patients with rheumatoid arthritis. Certain operations give consistently good results; others are indicated only under special circumstances; a few are experimental, and some are going out of use.
6. Hand surgery in rheumatoid arthritis as a

From the Rheumatoid Arthritis Unit, Baltimore City Hospitals.

result of improved techniques and better understanding of the disease process and its consequences. Again, some operations are indicated under most circumstances, others rarely, and some are no longer considered useful.

* * * * *

Rheumatoid arthritis generally follows one of three courses. A monocyclic course is characterized by a single attack of joint involvement with arrest and complete subsidence within about two years. About 35% of the patients follow this pattern.

The polycyclic type occurs in about 50% of the patients and is similar to the first type except that there are repeated flareups, usually without major deformities.

The progressive type, occurring in about 20%, is characterized by worsening over a number of years and results in crippling deformities.

* * * * *

1. Methods of Evaluation.—For most patients, general clinical examination, routine laboratory work, measurement of range of motion, estimation of the degree of pain in the joints, and x-rays will yield adequate information on which to evaluate the course of the disease and response to therapy.

A measurement of the "activities of daily living" estimates what the patient is able to do for himself at home. Many of these measuring systems are quite elaborate.[1] The one generally used in Maryland was described in the February Rehabilitation Notes.[2] Evaluations of the patient's psychological reaction and social factors may be quite helpful in estimating functional prognosis.[3]

In 1948 the American Rheumatism Association Committee on therapeutic criteria set up a simple system to describe the degree of total body function as well as x-ray changes.[4] Total function was divided into four classes ranging from no handicap (Class I) to largely or wholly incapacitated (Class IV). Radiologic changes varied from Stage I, with no destructive changes, to Stage IV, where ankylosis is present. Together the Class and Stage give a helpful description of the severity of the rheumatoid arthritis.

2. The Team.—Many patients respond well to salicylates and rest interspersed with carefully regulated exercises and heat. In some patients, however, these do not control symptoms, and some drug regimen will have to be added. Deformities may occur and advance despite all ordinary methods. The patient may begin to suffer depression, anxiety, and financial and vocational deterioration. The possibility of surgery may arise. At this point the team approach may have its greatest value.

The purpose of team evaluation is to work out the best possible program for the patient. The method used is to pool the knowledge and special examinations of a number of specialists in conference. The members of the team may be the patient's personal physician, a consultant in rheumatology, a physiatrist, an orthopedic surgeon, a hand surgeon, a psychiatrist, a social worker, and physical and occupational therapists. Sometimes a vocational counselor, the patient's employer, and the family contribute information necessary to make a logical decision as to the goals and program. For the plan to be successful, the patient must participate in making the decision.

Such evaluation seems particularly appropriate before any surgical procedures are carried out. The results of surgery in rheumatoid arthritis depend almost as much on the patient's motivation as on the procedure used. Therefore, evaluation of the patient's personality structure is essential. Furthermore, the physical and occupational therapists must understand what is contemplated so that postoperative exercises can be carried out.

In brief, the team approach is expensive and time-consuming, but in selected patients with severe disease and multiple problems, it is essential to good medical care.

REFERENCES

1. Lowman, E.W. (ed): *Arthritis. General Principles, Physical Medicine, Rehabilitation,* Boston: Little, Brown and Co., 1959.
2. Mahoney, F.I., and Barthel, D.W.: Functional Evaluation: the Barthel Index. *Maryland Med J* 14:61 (Feb) 1965.
3. Criteria for and Evaluation of Orthopedic Measures in the Management of Deformities of Rheumatoid Arthritis. *Arthritis Rheum* 7:549 (Oct) 1964.
4. Steinbrocker, O.; Traëger, C.H.; and Batterman, R.C.: Therapeutic Criteria in Rheumatoid Arthritis. *JAMA* 140:659, 1949.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

CONCERNING RESPONSIBILITY OF PSYCHIATRISTS AND OTHER PHYSICIANS FOR ALCOHOL PROBLEMS

A position statement authorized by the Council of the American Psychiatric Association, February, 1965

AN ADEQUATE NATIONAL ATTACK on alcohol problems* necessarily requires the application of the knowledge of many professionals reinforced by broad citizen support. Psychiatrists, together with general physicians and other medical specialists have a continuing obligation and responsibility for contributing their relevant clinical knowledge and skills to the treatment and prevention of alcohol problems. It is urgent and imperative that psychiatrists and other physicians better prepare themselves for their proper role in attacking these problems on a national scale that the medical contribution may become far more telling than it has been in the past.

Existing programs in the community for the management of alcohol problems are generally inadequate and need expansion and acceleration. General medical and psychiatric facilities, including general hospitals and psychiatric facilities, commonly discriminate against the patient with alcohol problems. Such meager services as they do render are offered in a spirit of therapeutic pessimism. What is needed are properly equipped and adequately staffed wards prepared to offer prompt and adequate treatment of acute and chronic physiological, psychological, and social disturbances associated with alcohol problems, and all of this in close collaborative relationship with other community agencies concerned with the management of such problems. The principle of a continuum of services in the community applies here as well as to other kinds of disorders.

All prepayment plans for defraying the cost of medical care through insurance should cover the person with presenting symptoms of alcohol problems who seeks treatment in medical settings on the same basis as for other illnesses.

Medically speaking, every person with alcohol problems should have the benefit of comprehensive diagnostic study including an assessment of his general health, his mental and emotional condition, and his social and economic adjustments. To concentrate exclusively on "the drinking problem" per se is to neglect the possibility of related diseases and various social and economic factors of possible critical import.

Treatment should reflect closely the results of careful diagnostic evaluation. As treatment progresses, furthermore, therapists should maintain

*The term *alcohol problems* is used advisedly in preference to the terms *alcoholic* and *alcoholism*, which, in our view, are stereotyping and oversimplifying, suggesting that all persons with alcohol problems suffer from the same affliction. They do not, except in the sense that drinking alcohol is contraindicated for them.



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continuous surveillance of the effects of that treatment and of intercurrent changes in the patient's condition. Critical review should continuously determine whether treatment is effective, appropriate, and adequate.

The patient and his problems with alcohol are affected by his social environment but they also affect that environment. Treatment programs should take this into account. Persons whose training is other than medical or psychiatric contribute substantially to the understanding and management of the patient. The treating physician should be willing to consult and collaborate with non-medical individuals and institutions involved without assuming administrative or other non-medical responsibilities in doing so. Such individuals include clinical psychologists, social workers, nurses, clergymen, vocational rehabilitation counselors, policemen, and others with qualifying education and background. Especially helpful with selected patients are organizations such as Alcoholics Anonymous. When collaborating or consulting with non-medical persons and organizations, the physician will of course be always mindful of his medical obligations to his patient. He has neither legal nor moral authority to abandon those obligations.

Present research activities investigating the nature and causes of alcohol problems are both commendable and productive. They have not yet, however, reached levels commensurate with the magnitude of the alcohol problem and its threat to our society. Urgently needed are greatly increased public and private monies for research, expanded research institutes and programs, and large numbers of fully trained personnel to conduct those institutes and programs. Procedures should also be developed which will greatly accelerate the adaption of research findings to the problems of patients and their promulgation to personnel involved.

We urge members of the Association to work with others in their communities for more adequate services for patients with alcohol problems in the context of this statement. We record our conviction of the need for undergraduate and graduate medical educators in general, and psychiatric educators in particular, to orient medical students in these constructive directions.

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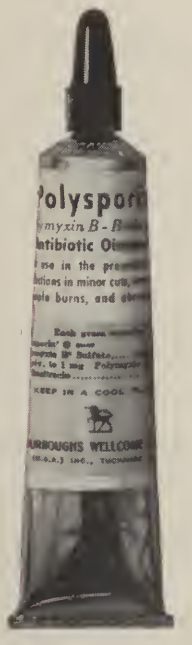
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Introducing the Pediatrics Page

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University Hospital

A NEED FOR PRESENTATION of more pediatric topics in the JOURNAL was expressed in a readership survey made by the editor, George Yeager, MD. The Maryland Chapter of the American Academy of Pediatrics has agreed to sponsor this page as a regular feature of the JOURNAL and has asked me to serve as its editor.

The aim of this page is to present topics of interest and importance to physicians and other readers concerned with the children of Maryland. We will appreciate any expression of desired subject material and will welcome timely and/or basic contributions from you. Manuscripts should range between 500 and 1,200 words, the shorter length if tables and figures are included. The manuscript should be referenced according to need. Contributions will be bylined.

This forum for discussion of problems of the fetus and newborn, the infant and toddler, and the child and adolescent will depend upon you, its readers and contributors, for guidance and criticism. With such assistance, we hope to provide a useful and interesting page for the welfare of children.

Ethics Corner

Using a Deceased Physician's Name

Q. Is it ethical to retain the name of a deceased physician on the door, telephone listing, and letterhead of the physician who has assumed the deceased physician's practice?

A. The AMA's Judicial Council has expressed the opinion that "In and of itself, it is not unethical . . . to continue to use the deceased physician's name in his practice for a reasonable length of time." The council has suggested, however, that it would be preferable for the physician to establish his own name in the practice of the profession as quickly as possible.



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Dentistry and the Mentally Retarded Child

BURTON, R. POLLACK, DDS*

COMPLETE DENTAL CARE is now possible for mentally retarded children, thanks to improved dental techniques, availability of hospital facilities, and the cooperation of pediatricians and anesthesiologists.

Providing dental care for the retarded child is primarily a problem in patient management. The dental problems, with few exceptions, are the same as those of the normal child. One of the exceptions is the greater frequency of periodontal abnormalities in the retarded child. Early loss of the supporting bone around the anterior region of the maxillary permanent teeth is often seen in mongoloid children. Epileptic children taking Dilantin demonstrate marked gingival hyperplasia. Other special dental problems usually arise from neglect and the lack of proper oral hygiene. Therefore, early detection of dental abnormality is extremely important to the retardate. Preventive dental procedures likewise are more important to children who are difficult to manage. Proper diet, drinking communal fluoridated water, topical fluoride applications, regular dental examinations with radiographs, regular prophylaxis, and proper restorative dental procedures constitute basic preventive practice for these children. These principles are no different than for the normal child except that they become more important due to complications of patient management.

When office treatment is impracticable because of lack of patient cooperation or due to complicated dental problems resulting from neglect, hospital facilities, including general anesthesia, can be used. Both physicians and dentists agree that general anesthesia administered for restorative dentistry should be confined to the hospital, where proper evaluation and medical management of the child can most effectively be carried out. Nasotracheal intubation should be done to ensure an airway. The presence of the endotracheal tube permits the dentist to pack the throat and thus prevent the aspiration of foreign particles. The use of the tube requires at least a 24-hour observation period postoperatively. This observation period coupled with the hospital's equipment and personnel, in readiness should an emergency arise, preclude the consideration of the care being rendered in a private office, no matter how well equipped it might seem to be. Adequate medical consultation is essential in the general anesthetic management of these handicapped children. Several hospitals in the Baltimore area have made possible the dental care of handicapped children by making available their facilities and personnel to dentists trained in hospital procedures.

With the availability of general anesthesia to facilitate dental care of the retarded, the dental profession has focused on another problem, that of early detection of abnormalities. An understanding of the pathogenesis of caries leads one to accept the fact that dental decay, even in its earliest stages, must be treated. All carious teeth, if left untreated, will progress to infection and pain and the eventual need for general anesthesia to facilitate their extraction. With the added difficulty of restoring missing teeth in these children, the most conservative dental treatment should be employed. One must not wait until the teeth are beyond repair to institute care. An additional problem in early detection of lesions in the handicapped is the inability of many of these children to communicate.

Most handicapped children, if dental needs are

*Associate Professor and Acting Head, Department of Pedodontics, University of Maryland, School of Dentistry; Director, Dental Treatment Center for the Handicapped, The Children's Hospital, Baltimore; Lecturer, Department of Maternal and Child Health, The Johns Hopkins School of Hygiene and Public Health.



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not complicated by neglect, can be treated in the dentist's office. Unfortunately, most dentists, because they may be unfamiliar with handicapped children, do not accept them into their offices. The University of Maryland School of Dentistry has under consideration plans which hopefully will do much to correct this situation. Among these are the establishment of a program of special lectures and regular extramural visits to facilities that provide care for handicapped and chronically ill patients. When completed, this program should expose the dental practitioners of tomorrow to the needs and methods of caring for the special patients within the community.

Dental pain is often unbearable, and many handicapped children suffer in silence. No matter how retarded the child and no matter how slim his habilitative prospect, he is entitled to live without pain and infection. Now that the community has supplied the facilities, through its hospitals, to treat these children, it becomes the responsibility of the health professions to see that all children, regardless of their handicap, receive proper dental care.

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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 3:—Pulmonary Embolism

THE PATIENT WAS A 24-year-old primigravida whose estimated date of confinement was December 12. The patient made her first prenatal visit at the third month and made a total of six visits. Findings were normal on all occasions, and she went into labor spontaneously on December 7. After an uneventful labor of six and one-half hours she was delivered spontaneously of a normal female child weighing slightly over 6 lb. There were no lacerations of the vagina, cervix, or perineum, and the placenta was delivered intact.

On December 9, the third postpartum day, she complained of mild malaise and headache. The tentative diagnosis of mild influenza was made at this time. Examination of the abdomen was negative, and the patient's lochial flow was normal. The following day the patient felt much better and was sitting up in a chair when she complained that she was unable to use her legs. She was put back to bed again. On examination the abdomen was negative, reflexes were normal, and the pupils were equal and reacted normally. Her temperature, which had been mildly elevated, returned to normal by December 12, but she seemed quite tense and nervous. On December 13 she was allowed out of bed again and seemed improved, but on December 14 she had a sudden acute episode and promptly died.

Following are positive postmortem findings: *Lungs*—numerous sections had marked atelectasis. Sections through the pulmonary vessels revealed numerous small emboli scattered throughout the entire vascular tree. *Uterus*—beneath an area of necrotic decidual material were found many large organized clots. The anatomical diagnoses were: a) atelectasis of lungs, bilateral; b) pulmonary embolism, massive, with thrombi originating from the uterine area.

COMMENTS

Approximately one third of maternal deaths currently occurring in this state are due to embolism, either amniotic fluid or pulmonary, of the type described above. The committee, on reviewing this case, classified it as a maternal death, nonpreventable. In the present state of our knowledge, there seems to be little that can be done on a routine basis to prevent tragedies of this type.

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RICHARD F. KIEFFER, MD
Chief, Surgical Service,
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SURGICAL TECHNIQUES used in the treatment of patients with pulmonary emphysema may be classified as follows:

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- Excision

Tracheostomy is of greatest value in tiding the patient over a crisis such as may occur during an episode of pneumonitis or during an acute exacerbation of chronic bronchitis. At such a time tracheostomy permits the effective removal of bronchial secretions, alleviates the burden of respiration by the elimination of nasopharyngeal dead space and the reduction of airway resistance, and facilitates the use of mechanical ventilators. For the patient in whom elimination of bronchial secretions is a chronic problem, a small tracheostomy tube may be left in place permanently for daily aspiration. At other times the tube is occluded by a plug, and respiration is accomplished through the normal airway. The technically difficult fenestration operation, which is designed to achieve this purpose without the use of a tube, has been largely abandoned.

Glomectomy, the unilateral excision of a carotid body, was enthusiastically endorsed several years ago as a safe, minor surgical procedure capable of effecting substantial improvement in many advanced cases of pulmonary emphysema. It now appears that much of the subjective improvement after this operation can be attributed to the psychologic overlay, which forms an important feature of the later stages of this distressing disease. It is also possible that this partial denervation of the chemoreceptor mechanism may render the patient less alert to the biochemical changes associated with ventilatory decompensation. The desirability of such an effect is questionable. At any rate, the procedure is no longer widely employed and is probably contraindicated in the patient who shows a tendency to retain carbon dioxide.

As a form of direct approach, tracheoplasty is applicable only to those unusual cases in which a forceful expiratory effort produces airway obstruction by the invagination of the posterior membranous wall of the trachea and large bronchi. In such cases bone grafts have been used as posterior splints to prevent such airway collapse. Although some success has been reported with this technique, in most patients the defect is too extensive to be correctable by a procedure limited to the trachea and main bronchi.

Otherwise, the direct surgical approach depends upon the fact that although emphysema usually involves both lungs diffusely the destructive changes are often more advanced in some areas than in others. When these destructive changes consist of blebs and bullae there is likely to be some compression of adjacent pulmonary tissue.

Under these circumstances the aim of surgery is to relieve such compression by the collapse or excision of obstructed, hyperinflated air pockets. It has been recommended that giant bullae be collapsed by closed catheter drainage. This usually involves a preliminary operative procedure to secure pleural symphysis before inserting the catheter with the aid of a trocar. Success is limited by the fact that what appears radiographically to be a single bulla is often compartmented by delicate septa of parenchyma. Moreover, the leakage of air through the catheter is often so large as to preclude the use of negative pressure. Although the results of this technique are usually disappointing it may occasionally be useful in a patient in whom a large bulla is contributing to ventilatory decompensation so severe as to prohibit a more definitive surgical procedure.

The most effective relief usually is achieved by open thoracotomy and a direct approach to the lung. When spirometric studies indicate no more than a moderate degree of generalized airway obstruction, large bullae can usually be excised and a good postoperative result obtained. It should be borne in mind, however, that the unilateral excision of bullae may cause enlargement of similar lesions in the contralateral lung.

The most common clinical situation is that of the patient with severe, diffuse airway obstruction in whom the destructive changes are not well localized. As with the patient with bullous disease, the success of surgery depends upon the presence of compressed lung which is capable of increased expansion and improved function. Unfortunately we have no certain means of determining preoperatively how much compressed lung is present. The decision concerning surgical treatment must be made on the basis of clinical judgment, taking into account the results of a meticulous appraisal of the patient's ventilatory capacity and a skilled radiologic appraisal of the anatomic situation. The presence of pulmonary hypertension or cor pulmonale suggests extensive loss of pulmonary vascular bed and contraindicates excisional surgery. One must be alert to the possibility of pulmonary fibrosis such as may result from granulomatous infections, sarcoid, or pneumoconioses. In such patients the fibrosis will limit re-expansion of the lung after excision of cysts and bullae.

Once the decision to operate has been made the patient is faced with a difficult, prolonged, and unusually hazardous postoperative period. The surgeon must be painstaking in his attention to details not only at the operating table but also throughout the patient's convalescence. In this type of surgery the morbidity is high and even the best results are seldom dramatic. Since operation is not directed toward the etiologic factors of the disease, improvement may not be sustained. Even in the patients who show the most gratifying symptomatic response it is usually difficult to show a corresponding gain by the techniques employed to quantitate pulmonary function. However, in carefully selected cases, excisional surgery performed under optimal circumstances can effectively relieve the more distressing symptoms of this disease.

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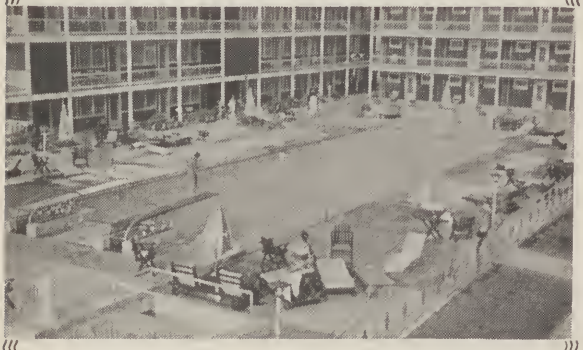
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According to Dr. Matthew Tayback, deputy commissioner of health, a downward trend in the birth rate is common throughout the nation and not peculiar to Baltimore. Although its causes cannot be pinpointed accurately, it is probably the result of 1) a swing away from the postwar large families, 2) better education, 3) increased interest in family planning.

Whatever the causes, the declining birth rate suggests a reappraisal of future plans for those agencies responsible for the health, welfare, and education of children.

Hospital, obstetric, and pediatric services, greatly pressed, will in all likelihood be able to give better service to a smaller population. Likewise, official and voluntary health and welfare agencies whose work is concerned with the community's children may find some lessening of the pressures that exceptionally high birth rates, particularly among groups in lower economic circumstances, have recently produced in our community. Similar adjustments no doubt will take place in the city's educational system.

Robert E. Farber, MD
Commissioner of Health



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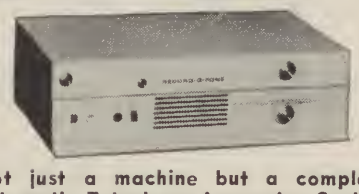
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Highlights

PAYMENTS FOR NURSING HOME CARE OF PUBLIC ASSISTANCE (WELFARE) CLIENTS

Negotiations are under way between the State Departments of Health and Welfare to implement the increase in payments from $135 to $210 per month for nursing home care of welfare clients. This increase has been approved by the General Assembly. It has been agreed that vendor payments to nursing homes, rather than the current practice of giving nursing home grants to the patient, will have several advantages, including the earning of more federal funds for the state. Under the plan being considered, the Health Department would make the vendor payments. It is hoped that more appropriate placement of patients, better supervision of patient care, more effective conformance to standards, and ultimately higher standards for licensing nursing homes will evolve. When procedures are developed, they will be submitted to the boards of both departments for approval. The target date for beginning the new payments is July 1, 1965.

PROPOSALS FOR IMPROVED REPORTING OF COMMUNICABLE DISEASES

In a meeting of representatives of the State Health Department and the Medical and Chirurgical Faculty, it was generally agreed that reporting of communicable diseases is inadequate except for the most serious infections such as meningitis, typhoid fever, and polio. Faculty representatives proposed revising and cutting the list of diseases which are required to be reported. Certain common childhood diseases such as chicken pox, mumps, and streptococcal infections might be reported by number only, on a weekly basis. All other communicable diseases would be reported on individual cards with full identification and diagnostic details. Improved procedures to insure confidentiality also were discussed.

Suitable report cards are being drawn up by the Health Department for consideration of all concerned.

IN-SERVICE TRAINING INSTITUTE

A two-week in-service training institute for personnel in day care centers for the mentally retarded was conducted in Annapolis during May, under the direction of Dr. Benjamin White, chief of the department's Division of Community Services for the Mentally Retarded. This is the sixth such institute, now a regular part of the department's continuing effort to develop the quality of care and to increase the scope of services available in centers for the severely retarded.

TRENDS IN FETAL AND INFANT MORTALITY—PREMATURITY

In view of the department's activities toward improved services for mothers and children, the Division of Statistical Research and Records has recently compiled a report on trends in fetal and infant mortality over the past 15 years and premature births over the past 12 years. This information points up those areas of the state which are in an advantageous or disadvantageous position with respect to these important health indices and provides baselines against which future progress may be assessed.



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HEAD START GRANTS APPROVED

Twenty-eight grants approved for Head Start projects in Maryland, as announced by President Johnson on May 18, encompass 120 centers, 178 classes affecting 4,823 children, with 409 paid staff members, and neighborhood volunteers and other volunteers numbering 389 and 297 respectively. The federal share of the projects amounts to $672,100; nonfederal is $101,254. Project Head Start is a special program of child development centers which combines health and medical, social welfare, and preschool educational components. It is especially designed for young children from severely socially and economically disadvantaged neighborhoods who lack the kind of environment and the appropriate stimulation necessary for success in school.

1965 MEDICAL STUDENT SUMMER TRAINING PROGRAM

The department is again offering opportunity for 10 weeks of field work in public health to students of the University of Maryland and Johns Hopkins schools of medicine. Each student will receive suitable public health assignments in various aspects of programs such as communicable disease control, maternity clinics, child hygiene clinics, preschool clinics, and environmental sanitation. The summer program is designed to give each man an opportunity to see work in the various fields of public health first-hand and to participate in it as actively as possible. The primary purpose of this program is to broaden the training and experience of the student in matters of community health.

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THE ALCOHOLIC PATIENT

LAST YEAR, FOR THE THIRD year in a row, more patients were admitted to Maryland's psychiatric hospital for the treatment of alcoholism than for any other diagnosis. More than two out of every five male admissions and one out of every eight female admissions were alcoholics. In addition, an appreciable number of patients with other diagnoses were reported to have a major drinking problem.

Alcoholism has been recognized as a serious community problem since the earliest days of recorded history, but as a disease for less than 10 years. It continues to be one of the most important public health problems, both in the United States and in many other countries. The total of alcoholics is not known, but it is estimated that at least 80,000 Maryland residents have a drinking problem sufficiently serious to interfere with their normal family relationships and work habits. This figure would indicate that one family out of 10 has an alcoholic member.

In recent years the number of alcoholic admissions has increased proportionally faster than other admissions. In 1960, 25% (1,161) of all admissions were diagnosed as alcoholics. This increased to 26.3% (1,330) in 1961, 28.6% (1,502) in 1962, 30.4% (2,188) in 1963, and 31.2% (2,449) in 1964.

Alcoholic patients come from all parts of Maryland and from all cultural, economic, and social community strata. Among last year's admissions: 1) 43% had an elementary school education, 45% had attended high school, and 10% had some college education; 2) 64% were white male, 11% were white female, 20% were nonwhite male, and 5% were nonwhite female; 3) 26% were Catholic, 71% were Protestant, and 0.4% were Jewish; 4) 3% were less than 25 years old, 53% were between 25 and 44, 41% were 45-64 years old, and the remaining 3% were 65 years or older.

Although nearly half of the alcoholic patients are self-admitted, many lack the motivations necessary for successful treatment. The unmotivated alcoholic poses a difficult challenge to the hospital staff. The probability of repeated hospitalization is high since successful treatment requires sustained abstinence, the development of constructive influences for continued sobriety, and resolution of the underlying factors related to the alcoholism problem. The average length of hospitalization is much shorter than for other patients, and the hospital treatment program is therefore limited. Last year, 40% were discharged within one month, and almost all of the remainder were released before the end of the first year.

Major variations exist between some religious and ethnic groups in the incidence rates of alcoholism. Studies of the factors responsible for these differences and their possible applications should contribute to the program to reduce the problem of alcoholism. Ultimate success depends on early diagnosis and treatment of alcoholics. This requires the expansion and close coordination of psychiatric hospital and outpatient services, public agencies, community groups, and interested and informed individuals.

Kurt Gorwitz



Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

WHAT ARE THE INFORMATION NEEDS OF THE PRACTICING PHYSICIAN?

At a preliminary meeting and workshop of the Advisory Committee on Information Requirements of the Practicing Physician, held at AMA headquarters on May 21, with six medical society representatives and several staff members from AMA present, the role of the medical library in biomedical communication was presented from various angles.

The purpose of the workshop was to determine the direction in which medical libraries, particularly medical society libraries, should be steering. This was the first of a three-stage program to identify the users of these libraries through a study proposed at the workshop. The final step will be to review the findings and determine further development.

Dr. Robert Hayes, UCLA School of Library Service, discussed the systems concept and information center, information networks in the U.S., and their impact on present library structure. Dr. Martin Cummings, director, National Library of Medicine, explained the NLM program, especially bibliographic control education program and decentralization with regard to its impact on present medical library structure.

Interesting user data from NLM reveal that one third of requests come from industrial and commercial sources, one third from medical schools and medical libraries, and one third from miscellaneous requesters. This library also experiences a 25% increase in the number of requests annually.

Dr. Cummings explained the status of NLM and the establishment of regional centers (libraries) and information centers. He emphasized that every application for establishment of a regional center under the Medical Library Assistance Act of 1965 (S597) through individual existing libraries would be evaluated on its own merits by the Board of Regents. These applications will be judged on the basis of studies made of medical school libraries, medical society libraries, and hospital libraries with respect to scope of service, such as number of physicians using, number of graduate and undergraduate students using, type of support, staff, relation to schools and other health groups.

As part of the session on the information center and classes of audience, Dr. Herbert Menzel, Bureau of Applied Social Research, Columbia University, discussed subsets of users in the medical profession, measurement of information use and need, its rationale and methodology.

After reviewing several studies now in progress, such as the California study on continuing education and needs of doctors, and that of the New Jersey Academy of Medicine, he defined the way information needs are identified, such as: *Topic*—1) how large is subject requirement, 2) analysis, addition of recent developments, and rare subjects; *Review Materials*—refreshers such as short courses and TV shows on medicine. He enlarged on needs by defining categories for delineating requirements, as potential users, opera-

tion purposes, and new communication facilities and techniques. Invention is sometimes the mother of need, he improvised.

Dr. Menzel said that we consider local studies worthwhile, as well as studies already completed or underway; for instance, Illinois Medical School is to study the prevalence of diseases and compare supply of literature on subject. He suggested a continuing education study to determine needs in the fields covered by local programs.

What's needed? What's available? What works? Give your library your ideas.

(More about this next month)

RECENT ACCESSIONS

REFERENCE

American Medical Association. Constitution and bylaws. 1964.

Encyclopedia of Associations. 3d ed. Gale Research Company. 1964.

Industrial Medical Association. Membership directory. 1964.

Maryland State Dept of Health, Division of Hospital Services. Directory of licensed nursing, convalescent and care homes, acute general hospitals, special hospitals. January 14, 1965.

OTHER

American Surgical Association. Transactions. Volume 82, 1964.

Association of American Physicians. Transactions. 1964.

Benson, Wilbur M.: *Tranquilizing and antidepressive drugs.* Thomas, 1962.

Blair, Emil: *Clinical hypothermia.* Blakiston, McGraw-Hill, 1964.

Craig, Charles F.: *Craig and Faust's Clinical parasitology.* 7th ed. Lea & Febiger, 1964.

Current therapy. Saunders, 1965.

Freeman, Sarah E.: *Medals relating to medicine and allied sciences in the numismatic collection of the Johns Hopkins University.* Evergreen House Foundation, 1964.

Goff, Charles W.: *Traumatic cervical syndrome and whiplash.* Lippincott, 1964.

Hershey, Solomon G.: *Shock.* Little, Brown, 1964.

Holt, Lawrence B.: *Pediatric ophthalmology.* Lea & Febiger, 1964.

Juvenile diabetes: adjustment and emotional problems. Proceedings. 1963.

Lodge, Thomas: *Recent advances in radiology.* 4th ed. Little, Brown, 1964.

Lovibond, S. H.: *Conditioning and enuresis.* Pergamon, 1964.

McBride, Earl D.: *Disability evaluation and principles of treatment of compensable injuries.* 6th ed. Lippincott, 1963.

Markowitz, Jacob: *Experimental surgery.* 5th ed. Williams & Wilkins, 1964.

Maryland. State Department of Health: *Maryland State Medical Facilities Survey and Plan.* 1964-65.

Puestow, Charles B.: *Surgery of the biliary tract, pancreas, and spleen.* 3rd ed. Year Book Medical Publishers, 1964.

Rollason, W. N.: *Electrocardiography for the anaesthetist.* F. A. Davis, 1964.

Scherf, David: *The atrioventricular node and selected cardiac arrhythmias.* Grune & Stratton, 1964.

Thompson, Robert H. S. (ed): *Biochemical disorders in human disease.* 2d ed. Academic Press, 1964.

Sobotta, Johannes: *Atlas of human anatomy.* 8th English ed. Hafner, 1963.

Year book of ophthalmology. 1964/65. Year Book Publishers.

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1965 Convention Scenes



Ever Curtis, MD, was guest speaker.



Mrs. John E. Baybutt (front row, third from left) takes her place among the past presidents. Others shown, front row: Mrs. Albert E. Goldstein, Mrs. William B. Stone, Mrs. David S. Clayman; back row: Mrs. E. Roderick Shipley, Mrs. D. D. Caples, Mrs. Walter M. Hammett, and Mrs. Charles H. Williams.



Mrs. John E. Baybutt congratulates her successor, Mrs. Martin E. Strobel.

New officers include Mrs. Martin E. Strobel, president; Mrs. George Malouf, treasurer; Mrs. Karl F. Mech, third vice president; Mrs. Archie R. Cohen, president-elect; Mrs. Wallace H. Sadowsky, first vice president; Mrs. Raymond Yow, fourth vice president; and Mrs. DeWitt E. DeLawter, recording secretary. Officers not pictured are Mrs. Raymond L. Markley, corresponding secretary, and Mrs. M. McKendree Boyer, second vice president.







Margie Warres—

President, Woman's Auxiliary to the Baltimore City Medical Society

MRS. LEONARD WARRES HAS the distinction of being listed in *Who's Who in American Women.* After interviewing Margie, I can readily see why she has been chosen to be in this company.

On her charm bracelet Margie wears a DAR medallion awarded to her at the Harrington, Del., High School for being the "best all-around girl." Other high school achievements included winning regional spelling and speech contests and being class valedictorian.

Another charm she treasures is one awarded more recently from the Board of the Central Scholarship Bureau on her tenth anniversary as executive director.

While at Goucher College, Margie met her husband-to-be, a student at the University of Maryland Medical School. Leonard Warres did a friend a favor by consenting to be a blind date for a friend of Margie's. As it happened, they switched partners for life, and all four are still good friends.

After two years at Goucher, Margie married Dr. Warres and moved to New York, where her husband went into graduate training. Margie continued her education at Brooklyn College and graduated magna cum laude. She also received an award for her department major, social science. While her husband served overseas with the Army, Margie studied at the University of Pennsylvania and earned the degree of Master of Social Work.

After the war the Warreses returned to Baltimore, where Dr. Warres set up practice as a radiologist. He is now on the staff of University, Sinai, Baltimore County General, Provident, and Baltimore Eye, Ear and Throat hospitals.

Margie wasted little time in becoming involved in many charitable and worthwhile organizations. She was the first executive secretary of the Public Welfare Committee of the Maryland State Conference of Social Welfare, which she started more than a decade ago, and she is still a member.

In the past she has been active on boards and committees for the following: Park School, Hadassah, Green Valley Swimming Club, Levindale Home for the Aged, Sinai Hospital Auxiliary, the National Conference of Christians and Jews, Red Cross, Associated Jewish Charities, and others.

She is now on the board of the Parents Association and the Religious School Committee of Baltimore Hebrew Congregation, as well as on its Social Action Committee. She is a director on the Board of Jewish Education of Baltimore and the Parents Council of Baltimore and is on the advisory board of the Child Study Association of Baltimore. She has held numerous positions in the Child Study groups, among them that of president of Chapter #85 and later of the citywide association.

Mrs. Warres has moderated panels on TV and radio for various groups and has written a number of articles, usually dealing with the Central Scholarship Bureau. She's a former co-editor of the *Round Up,* a publication of the Women's Division of the Associated Jewish Charities, and a past president of the Wallis Investment Club.

Her son Steve, in a special fund book for the Central Scholarship Bureau, wrote the following:

> In spite of all these activities, however, Margie has always given first call on her abundant energies and devotion (outside her family) to Central Scholarship Bureau, which has flourished largely because of the dedicated efforts of its Executive Director for almost 14 years.

The Central Scholarship Bureau, which is one of the most unusual organizations of this type in the country, was formed more than 40 years ago as a small, local group. Under the direction of Mrs. Warres and her associates, it has expanded into a

continued on page 115

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

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8 to 12 years–10 mg. (1 tsp. 5 times daily)

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In the Woman's Auxiliary to the Baltimore City Medical Society, Margie has been a member of the board for five years since 1959. She has been chairman of the Medical Research Committee, Membership Committee, and Student Aid Committee. She has served terms as vice president (1962-1964), and president-elect (1964-1965), and now is president.

Dr. and Mrs. Warres have two sons, Stephen, 19, and Neil, 14. Steve is completing his sophomore year at Princeton, where he writes for the daily *Princetonian* and is an associate editor of the *Tiger* (humor magazine). At this point he has apparently switched from pre-med to philosophy. Neil is a freshman at Park School, enjoys track, and is active in the school orchestra and the Maryland Youth Symphony.

All four in the family enjoy music. Margie and Neil play the violin, probably influenced by Margie's father, who played first violin with the Philadelphia Orchestra and the New York Philharmonic Orchestra. Steve and his father play the piano. They also share enjoyment of literature, theater, and travel.

Dr. and Mrs. Warres have taken their children on many trips throughout the world, including Turkey, Iran, Israel, Greece, Italy, Spain, Portugal, Great Britain, Holland, Belgium, Switzerland, Mexico, Caribbean islands, Canada (from the east to the west coast), and the United States from north to south and east to west. Their longing now is for a trip to the Orient.

Because of her enthusiasm for travel, Margie organized the first jet charter flight to Europe for the Medical and Chirurgical Faculty of Maryland, in 1960. This has become an annual Faculty event.

There is no doubt in the mind of any Auxiliary member who has worked with Mrs. Warres that this year should indeed prove to be a successful, stimulating, and rewarding one for Margie (whose mental wheels have been grinding away and storing data for "her" year), for her Board, and the entire Auxiliary!

Mrs. Irving J. Taylor

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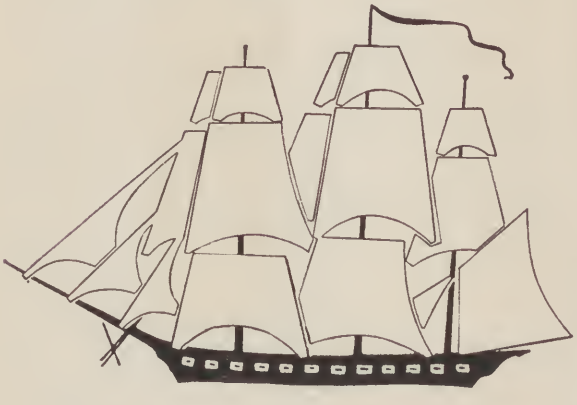
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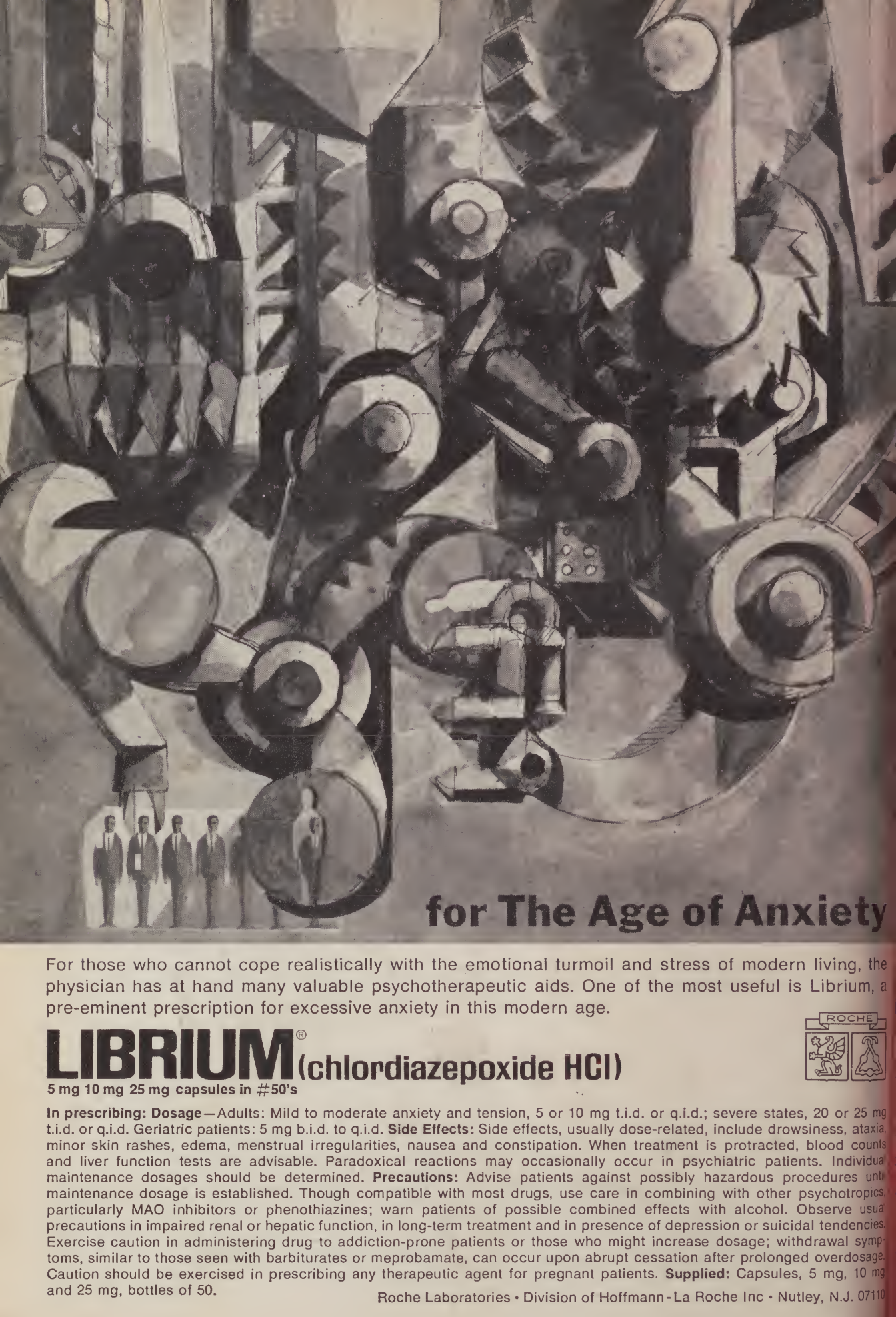
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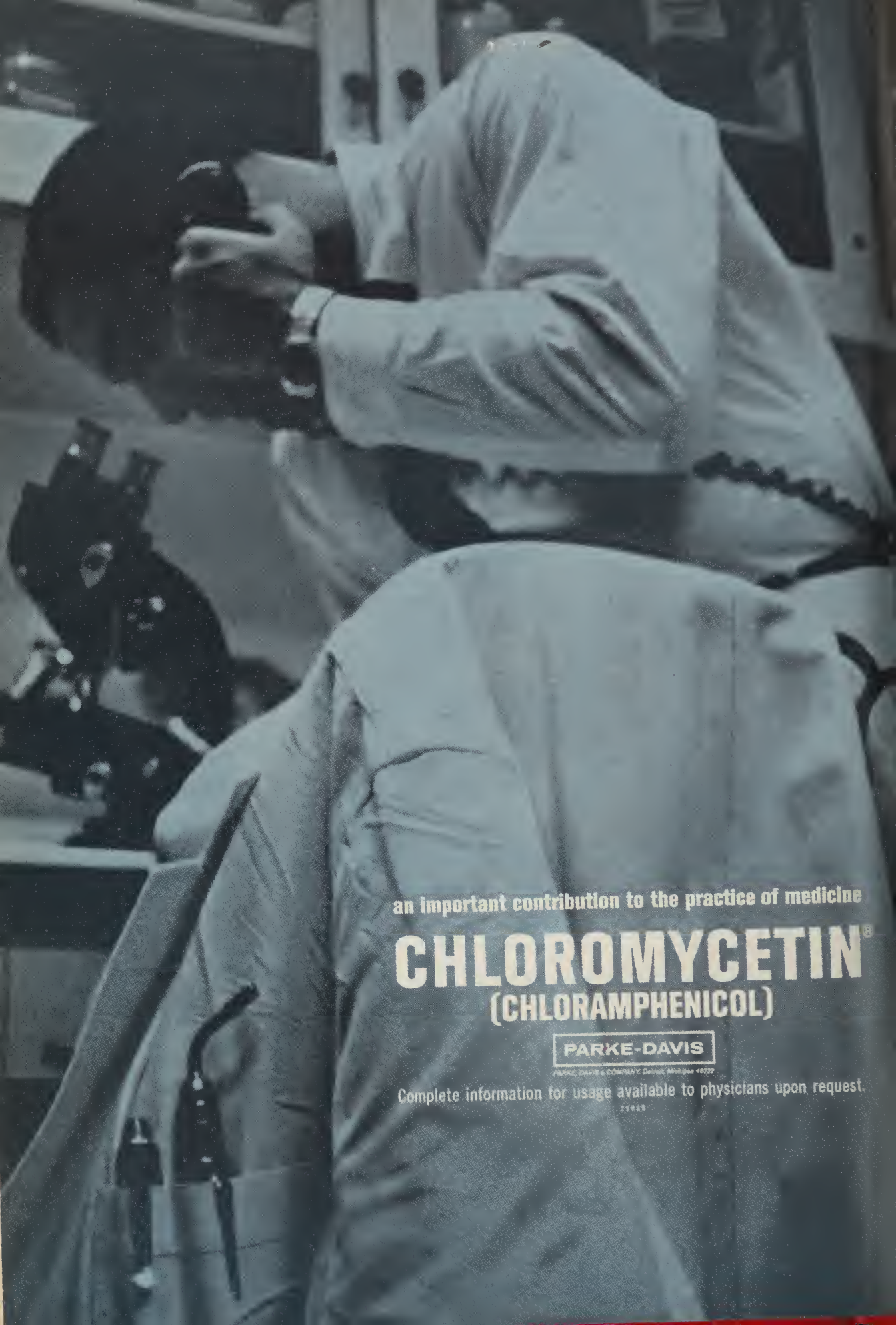
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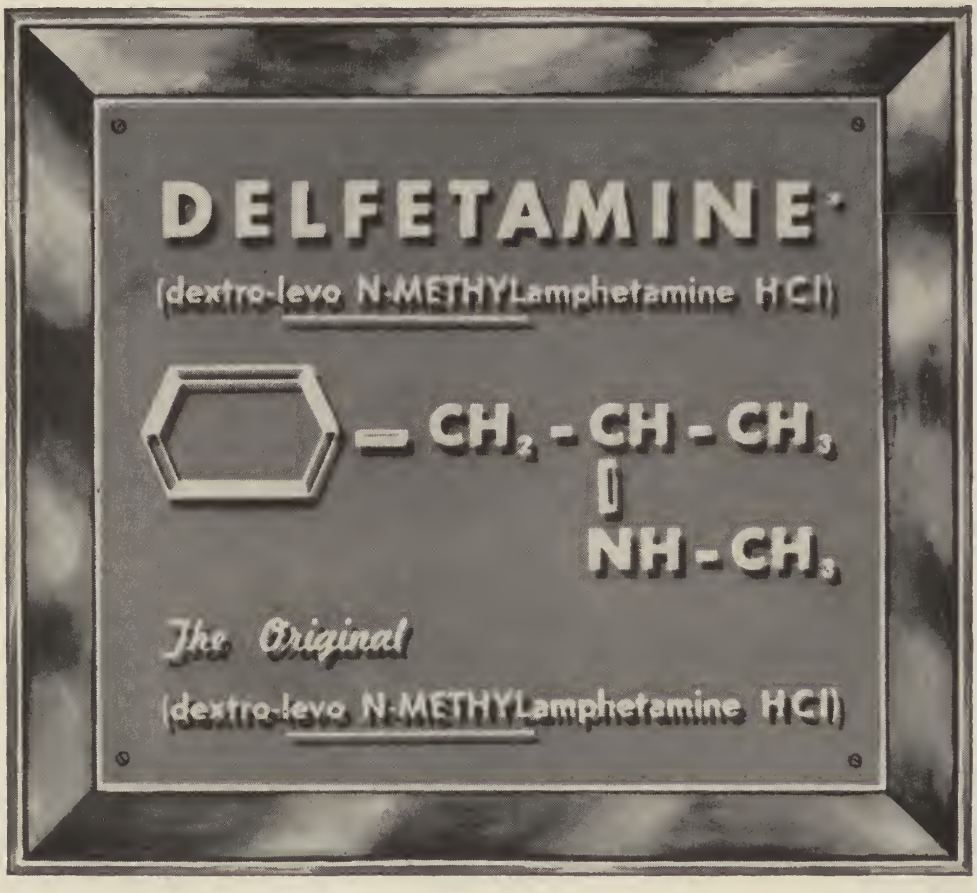
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MARK THIS IMPORTANT DATE ON YOUR CALENDAR

September 10—Semiannual meeting, Medical and Chirurgical Faculty of the State of Maryland, Ocean City. See Program pp. 51-56.

September 9-11—Delaware Academy of Medicine, Wilmington

AUSCULTATION CONFERENCE

The Delaware Heart Association will hold a teaching seminar on heart sounds. The instructors are Doctor Alan Weintraub and Doctor Antonio DeLeon of the Division of Cardiology, Georgetown University. Using live patients, they expect to cover the subject in depth during three morning sessions. Individual stethophones will be provided. AAGP accreditation category I applied. Delaware Heart Association, 2108 Baynard Boulevard, Wilmington, Del.

September 15—9 AM-1 PM—Holy Cross Hospital of Silver Spring

PEDIATRIC SEMINAR

Seminar on "Diarrheal Problems in Infants and Children." Sponsored by Department of Pediatrics, Holy Cross Hospital of Silver Spring, 1500 Forest Glen Road, Silver Spring, Md.

September 15-June 15, 1966

TUTORIAL PROGRAM IN CARDIOLOGY

Nine month program offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif. Intensive program covering field of cardiovascular diseases. Especially designed for physician in private practice who wants an academic year of organized instruction with freedom from direct patient responsibility. Write to E. Grey Dimond, MD, 476 Prospect St., La Jolla, Calif.

September 16-18—Portsmouth, New Hampshire

NEW ENGLAND SOCIETY OF ANESTHESIOLOGISTS

Annual Fall Conference to be held at Wentworth-By-The-Sea.

September 19-24—Sheraton Cadillac Hotel, Detroit

MICHIGAN CENTENNIAL

Michigan State Medical Society will celebrate a century of service in medicine. Each day will be a convention in itself with a separate theme; September 19, Medicine and Religion Day; September 20, Medicine and Business, Industry and Communications Day; September 21, Medicine and Medical Organization Day; September 22, Medicine and Science Day; September 23, Medicine and Voluntary Health Day; September 24, Medicine and Government Day. Michigan State Medical Society, 120 West Soginaw St., East Lansing, Mich.

October 2-3, Chicago

ETHICS AND PROFESSIONALISM

Notional congress sponsored by AMA. Drake Hotel. Speakers include James Z. Appel, MD, AMA president, and Walter H. Judd, MD, former U.S. congressman. For further information write to James H. Berge, MD, chairman, Judicial Council, Americon Medicol Associotion, 535 N. Dearborn St., Chicago, Ill. 60610.

AMERICAN HEART ASSOCIATION RESEARCH GRANTS

The Americon Heart Association is occepting opplicotions from research investigators for support of studies to be conducted during the fiscal yeor beginning July 1, 1966. September 15, 1965, is the deodline for submitting applications for estoblished investigatorships ond odvanced research fellowships. Further informotion and application forms may be obtained from the Director of Research, Americon Heart Associotion, 44 Eost 23rd Street, New York, N. Y. 10010.

ACP POSTGRADUATE COURSES

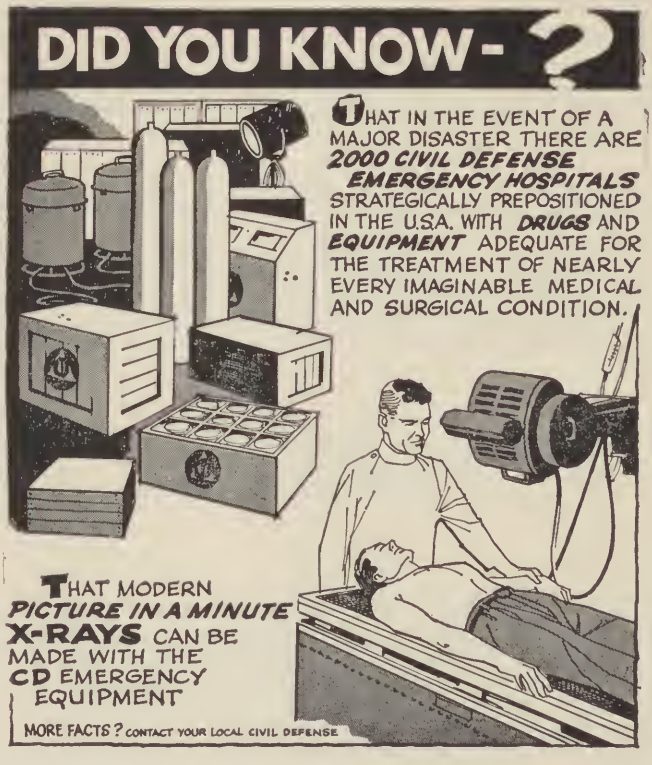
Course No. 1—"Bosic Mechonisms in Internol Medicine." September 20-24, Medical College of Virginio, Richmond.

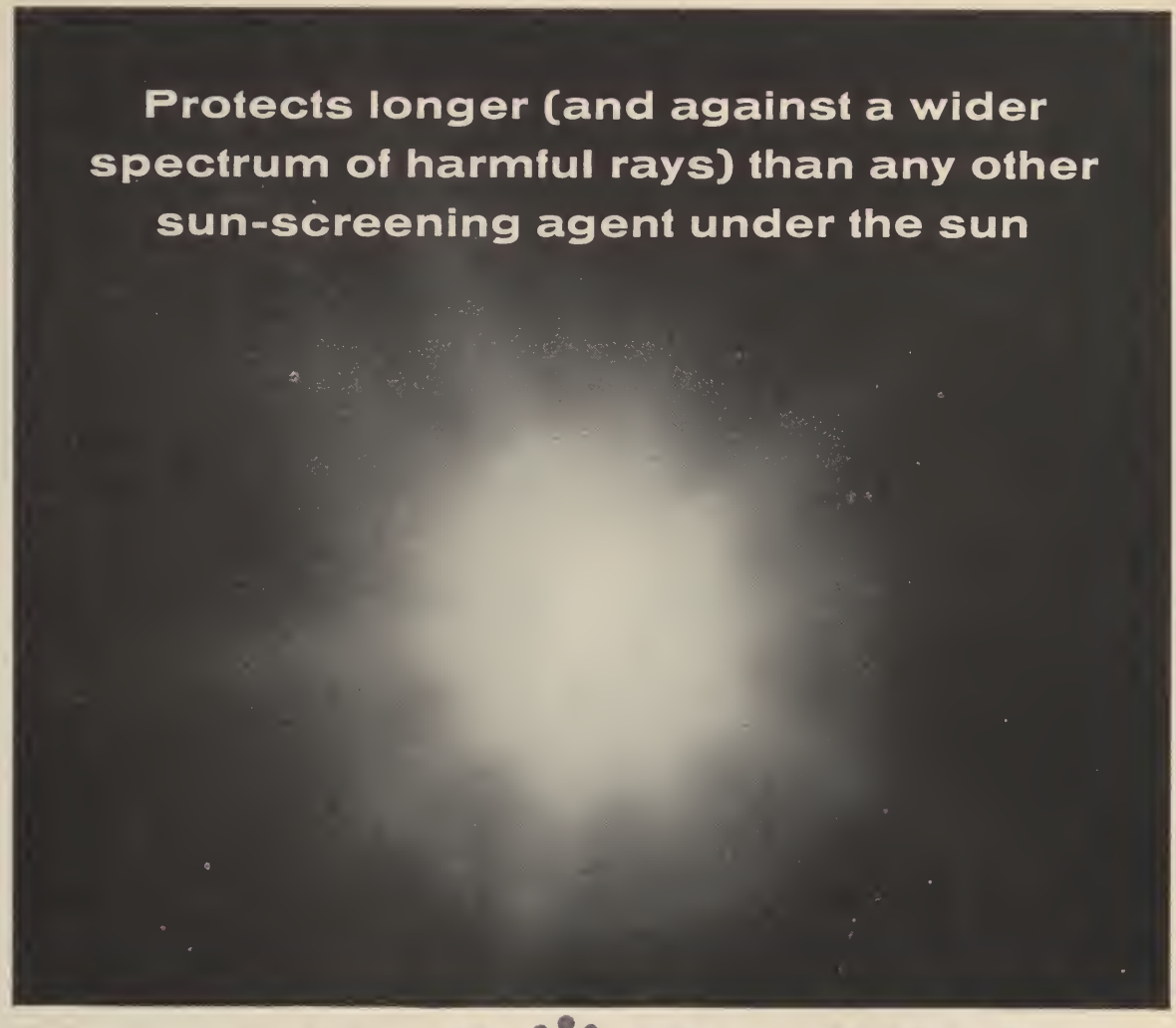
Course No. 2—"Morphologic, Biochemicol and Clinical Aspects of Hepotic Disease." October 11-15, The Chicogo Medical School, Mount Sinoi Hospitol, Chicago.

Course No. 3—"The Rheumotic Diseases: Pothology, Diagnosis and Treatment." October 18-22, Robert B. Brighom Hospital, Boston.

Course No. 4—"Moleculor Biology: Its Implications for Modern Medicine." October 25-27, University of Chicogo Center for Continuing Education.

Inquire: Edword C. Rosenow, Jr., MD, executive director, The American College of Physicians, 4200 Pine St., Philadelphia, Po. 19104.





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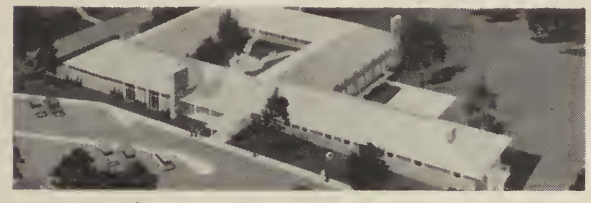
For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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Maryland State Medical Journal
Vol. 14, No. 8
August, 1965

THE PRESIDENT CONTINUES TO SPEAK

ALBERT E. GOLDSTEIN, MD

In a report to the Society last year, some attempt was made to point out briefly to physicians a few of the advances made in medicine in the past. Now, to continue on, some of the advances occurring at present as well as looking somewhat into the future will be discussed. These will relate to the progress which will benefit both the physician and medicine at present as well as in the future. This will apply both to Maryland as well as to the world at large. Mention will also be made of what our Society is doing relative to progressive steps.

Political implications and complications will be excluded as much as possible.

Possibilities and probabilities are considered, but frequently they become too impractical, and we are forced to look into the crystal ball and then hope for realization. These usually terminate incorrectly. There are certain impractical observations which cause many of us to be imaginative. Imagination is important to the physician, personally; without it he fails to look into the future.

Surely, our early great physiologists, chemists, physicists, bacteriologists, and even surgeons and others have visualized with imagination some of our past and present great accomplishments in the last half century. Many of you can recall just in the past quarter of a century, and even to the present day, many of the imaginative thoughts that have materialized through research in bacteriological, biochemical, and surgical studies, etc. Otherwise, we would have not been able to observe the strides that have been made in the management of infections, transplantations, and homotransplantations of tissues and organs. The use of the Salk vaccine is one example which exists today; more recently, studies of the sputum have given us some thoughts about cancer in smokers.

Presidential address, presented April 22, 1965.

Important advances exist today in the treatment of cardiac and congenital conditions, but less success has been achieved in the treatment of the major malignancies.

In our own research laboratories, we have been particularly interested in the past 10 years in homotransplantation, and while we have met with some success, it is far from being perfected. To me, the strides made in transplantation and homotransplantation of tissues and organs hold a great deal, and I believe that it will play a great part in the future of medicine.

The introduction of the artificial kidney in other laboratories, as well as ours, in the early fifties produced great strides in the treatment of the various kidney conditions. At one time many of these conditions were hopelessly treated, but today, with the use of the artificial kidney, many of them have been greatly improved and some have been cured, depending upon the disease for which it is applied. Many of the schools and hospitals today have set up kidney stations for patients suffering with certain kidney diseases.

Maryland is a small state when one speaks of its acreage and population. For the same reason, it is small in the number of physicians that are embraced.

When one thinks of the small number of physicians in the state, one can immediately realize how deficient we are in numbers. If one will recognize the high percentage of physicians who are engaged in parttime or fulltime research work, it is observed that we are left with a small group of physicians to care for the ills of the patients in the community. Additions and modifications are necessary if we expect to hold our position in Maryland.

Even though Maryland is small in numbers of physicians, it is a very active state as far as medicine is concerned, because some of the localities, such as Baltimore, Bethesda, Edgewood Arsenal, Silver Spring, and others, are active in research.

Where the percentage of research is high, as it is in our two medical schools and in other hospitals and institutions in Maryland, it makes for a great medical center from which a great deal of research emanates. The result is that it makes our state, particularly our largest city, Baltimore, a center of medical education.

For years, Baltimore has been considered the medical center of the United States. In the past few years, we have had great competition from cities like Boston, New York, Chicago, Los Angeles, San Francisco, Cleveland, and Rochester, Minn.

It is not unusual to see and hear of the best talent and performances coming from the various clinics in the cities mentioned. We must continue to make strides lest we jeopardize our position in medicine, not only in Maryland but throughout the United States and the world.

All things I have mentioned place our Medical Society in a position where it is forced to carry on as a major business development, and this is exactly what it is doing. It would surprise you to no end if you were told of some of the other enterprises the Medical and Chirurgical Faculty has undertaken in the past few years.

We are indeed fortunate to have with us this evening some of our living past presidents who have participated in the performances of some of these remarkable accomplishments.

Each year the work has increased at the Faculty. Where this occurs it is necessary for more committees to be formed and to function actively.

I can recall in my early days at the Faculty that we were operating with five special committees aside from the Council. In the past year, we operated with 25 major committees, each composed of a chairman and from 10 to 20 physicians, meeting from every one to four weeks during the year. This has been a must in the past few years to enable us to cover the necessary work of the Society.

Our legislative work has increased by leaps and bounds, but fortunately we have been provided with competent leadership in the Society with excellent results in most instances.

We have attempted to keep in close contact with our component medical societies by visits when necessary and otherwise. During my year as president-elect, I visited many of the component societies, but during my presidential year there was less activity due to my unfortunate illness; but I can assure you that it was not neglected. During my years as president-elect and president, several novel ideas were introduced which have been of tremendous value to our members and the Society.

An educational program has been introduced this year and an invitation extended to the allied medical groups when, this past September, the Faculty sponsored a conference on community mental health. I attended this, and, to my amazement, crowded audiences were present. In March, 1965, a seminar on nutrition was sponsored by the Society and was attended by more than 400 persons. These two projects were entirely new and reflected to the public our concern of their health.

We are attempting to establish a permanent speakers bureau on scientific subjects, to be made available for hospital staffs and medical societies. A tetanus immunization informational program has been developed and made available to component societies and industrial medical departments. Membership information booklets have been published and made available to members. We want all our members to be fully informed of the wide range of services available to them under Faculty auspices. An actuarial study of our insurance programs is being made and should be ready for the membership in a few months. The inauguration of health evaluation tests for physicians has proved very beneficial. Many more accomplishments of our many busy committees could be mentioned. Time does not permit me to go on, but it can definitely be said that without the cooperation of the various committee chairmen and their associates, this big business of the Medical and Chirurgical Faculty could not have kept up with the work of some of the other state societies. We find that we are far ahead of some others.

Medicine is going right ahead in Maryland and probably at a faster gait here than in many other places. Responsibilities are placed on many of our young physicians, and opportunities are knocking at the doors of many of these same young physicians.

Sometimes we analyze our positions and opportunities for the younger man. We are criticized for engaging too many of our younger men into the field of research. The cry is that so many are involved in research, leaving too few to care for the real ill. But progress must go on regardless, and other methods must be found to increase the number of practicing physicians. It is difficult sometimes to say whether the population as a whole benefits by increasing the amount of research performed in some of the institutions. There is no doubt that tremendous sums of money are spent in research, frequently being duplicated, many times causing a waste of a great deal of money and time. This entire country is now on a research basis, offering ample opportunity for the man in medicine. We are in a unique position, and I think that ultimately both the physician and patient will benefit. Realization is the end factor; therefore, medicine holds a great future for our physicians. I still believe that the young physician should engage in the imaginative field because many ideas were once thought impossible. Some of them have been realized, and some have gone beyond our realization. One imaginative thought I held years ago was that someday I might be made president of the Medical and Chirurgical Faculty of Maryland. I was told it was impossible. It has materialized, and I appreciate the honor very much. I am thankful to all the members for their confidence in me and appreciate their cooperation.

I was fortunate to have a group of capable individuals as Council members and an Executive Committee headed by Dr. Russell Fisher, together with Dr. Robert Campbell as president-elect.

All of the above mentioned accomplishments and advances would never have materialized without the assistance of a remarkable executive staff composed of Mr. John Sargeant, an able, untiring, accomplished executive; Mrs. Anna Wynde Leake, Mrs. Genevieve Ritchie, Miss Mary Sue Hudson, and Mrs. June Miller are equally accomplished individuals. Our former assistant executive secretary, Mr. Theodore Chilcoat; Mrs. Constance Galton, Mr. Joseph Harrison, together with all their associates too numerous to mention by name, and our librarian, Mrs. Elizabeth Sanford, helped considerably.

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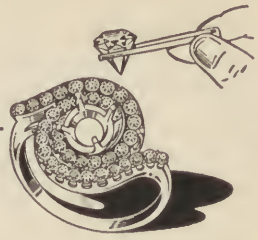
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EXECUTIVE SECRETARY'S NEWSLETTER

August, 1965

REFERENCE COMMITTEE MEETING

The Reference Committee meeting is scheduled for

THURSDAY, AUGUST 26, 1965,
at 8:00 p.m.

in the Faculty Building.

The following resolutions, having been introduced by July 16, 1965, will be considered at that time. Individuals who wish to express their views should be present to comment on them.

1S/65 - Payment of Physicians by State of Maryland for Services Now Provided Free to In-hospital Medical Care Patients

2S/65 - Support of American Medical Association in amendment of Federal Laws providing for a Redefinition of Civil Defense

3S/65 - Non-participation on part of Faculty and its individual members in H.R. 6675, or Measures similar to this

4S/65 - Establishment of a Civil Rights Committee of the Medical and Chirurgical Faculty

These resolutions are to be considered by the House of Delegates at the Semiannual session, Friday, September 10, at Ocean City, Maryland.

Members may obtain copies of the resolutions through their Delegates the Faculty office.

CORRECTION

In recent issues of the NEWSLETTER we have made reference to the issuance of Work Permits. The physician may not issue "Work Permits" as such, but may issue a certificate to indicate the minor is fit to perform the work he plans to engage in. This may be in any form the physician wishes such as on a Rx blank, letter or any other form.

The actual issuance of the "Work Permit" is the responsibility of the Department of Labor and Industry.

NEWS NOTES

Douglas J. Sanders, D.D.S., has announced his full-time specilization in Pedodontics.

Samuel P. Scalia, M.D., has been elected a Fellow of the American College of Chest Physicians.

Charles S. Rafky, M.D., has opened his office for the practice of Psychiatry at 1010 St. Paul Street, Baltimore.

David R. Morales, M.D., has opened his office for the practice of Obstetrics and Gynecology at 1654 East Belvedere Ave., Baltimore.

Howard Moses, M.D., is engaged in the practice of Neurological Medicine and Pediatric Neurology at the Medical Arts Building, Baltimore.

Certified as Diplomates of the American Board of Anesthesiology are the following physicians:

Jane B. Battaglia, M.D., Kyl S. A. Ninneman, M.D., Chin-Hsin Lin, M.D., Hak Suh Lim, M.D., Baltimore; and Maureen Huse Bull, M.D., Ganka Benderev, M.D., of Bethesda.

PKU RULES AND REGULATIONS

The State Health Department has issued Rules and Regulations with respect to the PKU testing of all newborn infants now required by law.

Complete details are available through local health officers or the State Health Department or hospital administrative offices. Only exceptions to the regulations are for religious objectors.

Births outside of the hospitals are the responsibility of the physician or the midwife.

CONGRESS ON ETHICS

The AMA has announced a Congress of Medical Ethics and Professionalism at the Drake Hotel, Chicago, October 2 and 3, 1965.

Representatives of the Faculty will be in attendance at this meeting, but individual members are also welcome to attend. Details may be obtained through the Faculty office.

John Sargeant

Executive Secretary

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JOHN SARGEANT EXECUTIVE SECRETARY

COUNCIL, JUNE 17, 1965

1. Legal defense was ratified for various members requesting it.

2. At the request of the respective component societies, emeritus membership is to be recommended for Ralph Cohen, MD, Montgomery County; David R. Brewer, MD, Washington County; and Margaret B. Ballard, MD, Baltimore City.

3. Supplemental reports of the Laboratory Services Subcommittee of the Liaison Committee, one dealing with blood banking* and one with ethical operation of clinical laboratories† were adopted.

4. A Liaison Committee report‡ concerning the responsibilities and duties of registered nurses in relation to the Medical Practice Act was adopted with the understanding that the information be distributed to the groups concerned.

5. Proposed rules and regulations concerning PKU testing were approved with the understanding that they are subject to review in final form by the Liaison Committee.

6. The chairman of the Subcommittee on Aging presented a proposal for printing 5,000 copies of a handbook on retirement counseling to be distributed to those Faculty members who might encounter this problem in their practice. Additional copies would be available at 10¢ each. The cost would be charged to the educational fund raised from the $50 assessment. This was approved.

7. A proposed program for tuberculin testing of school children was recommitted to the Committee on Postgraduate Education, Preventive Medicine, and Public Health for further study. It was recommended that the family physician be specifically included in the program and that specific therapy should be his decision.

8. The chairman of the Professional Fee Fund Committee presented the proposed letter and questionnaire on ethical arrangements for mailing to the Faculty membership. This was approved as amended.

9. After considering the question of payment for podiatry services under the state medical care programs, the Council voted to recommend no extension in professional services now offered.

10. An increase of $1 in each category of payment under the medical care program is to be suggested. The Council further adopted the policy that the physician has a right to a reasonable remuneration for medical services rendered, whether inpatients or outpatients, in the medical care programs.

11. Various recommendations of the Treasurer were adopted.

12. Two recommendations of the Public Relations Committee were adopted.

*See page 24 for full text of report.
†See page 28 for full text of report.
‡See page 32 for full text of report.

One provided for sharing the cost of the TV programs sponsored by the Baltimore City Medical Society, with the Faculty to receive appropriate credit. This expense will come from the educational fund. The other recommendation concerned reemphasizing Faculty policy with respect to participation in component society activities, this to be done by mailing a copy of the policy to presidents and secretaries of component societies.

13. Faculty participation in a planning group on areawide health facilities was approved, and the President was authorized to appoint a Faculty representative.

14. A proposal that physicians not be bound by service benefits under the Student Blue Shield program when the patient uses private room facilities and has a private duty nurse was accepted in principle and is to be referred to the Blue Shield Board.

15. Continued support of legislation to effect privileged communication between patients and psychiatrists was voted.

16. The report of the Governor's Commission to Study the Shortage of General Practitioners was endorsed.

17. The recommendation of the Policy and Planning Committee concerning the use of the term *medical center* or *medical clinic* was approved.*

18. The suggestion that membership of 50 years in the Faculty be recognized by awarding a 50-year membership pin was adopted.

19. The Policy and Planning Committee reported on its investigation of *Maryland State Medical Journal* operation and recommended that "the State Journal is necessary to our proper function in and awareness of local medical affairs and problems . . ." and that it be continued even though at a cost to the Faculty. This was adopted.

20. The Ad Hoc Committee on Tuberculosis presented a report and requested Faculty support of various procedures for locating and treating tuberculosis. This was adopted.

21. The President was authorized to send the following letter to Milton S. Eisenhower, president of the Johns Hopkins University:

Dear Dr. Eisenhower:

On the occasion of precommencement exercises at the Johns Hopkins University School of Medicine, Ivan L. Bennett, Jr., M.D., Baxley Professor of Pathology of the Medical School, made remarks which, by and large, were detrimental to the medical profession.

Since that time, many physicians throughout the state have expressed their concern over the use of this occasion for the expression of what is considered to be the personal views of Dr. Bennett. While all physicians would strongly defend the right of Dr. Bennett to his personal feelings, there is considerable concern that the impression has been given indicating that these are also the feelings of the Johns Hopkins University Medical School Faculty.

The Council of the Medical and Chirurgical Faculty, at its June 17, 1965, meeting, considered this matter at some length. The Council heartily endorsed my personal views and those of the Council Chairman, that we should not oppose Dr. Bennett's position publicly. The Council did, however, feel that this matter should be brought to your attention.

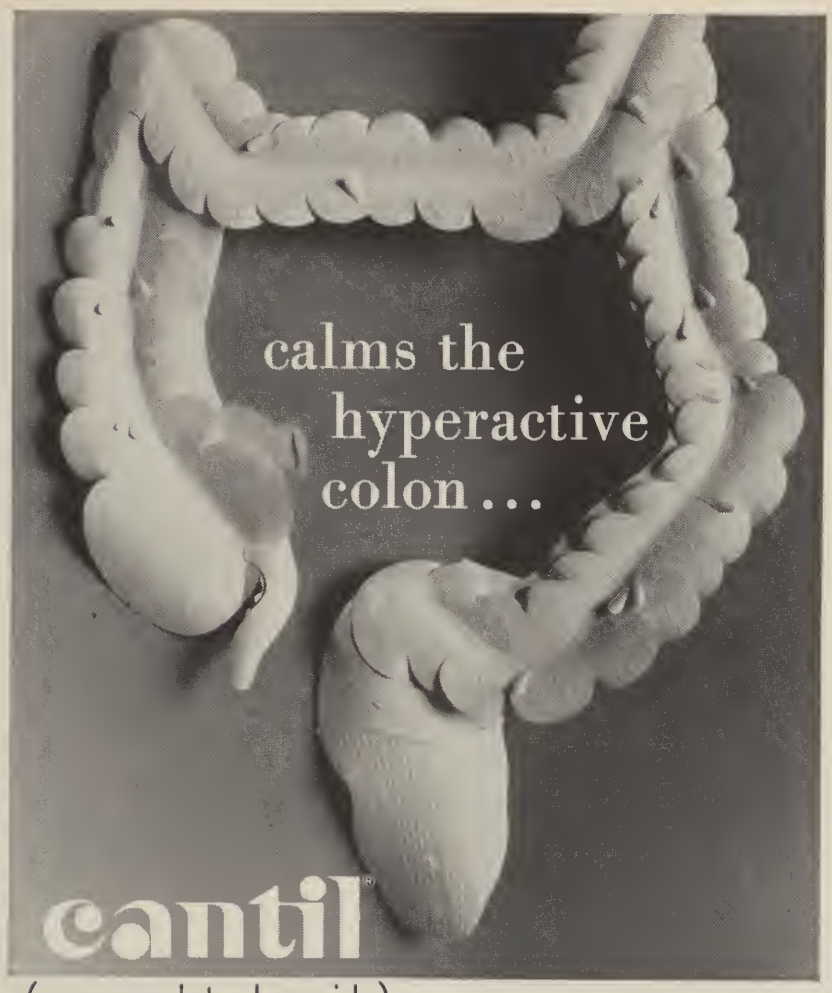
It is strongly felt that intemperate remarks such as these do nothing to bolster the confidence of the public in the medical profession. While we all realize there are shortcomings in any profession and in any actions taken by groups, nothing is served by airing such differences in such a forum. We would rather that attempts to correct any shortcomings be discussed with the appropriate officials of the Medical Society of which Dr. Bennett is a member. In this manner, the public as well as the profession is better served.

Like Dr. Bennett, the members of the medical profession in Maryland are interested in providing the highest quality of medical care to the public. If any ways can be found to improve such care, we are more than willing to discuss them and promote them in the interests of the public.

It is our strong wish and hope that you and the members of the Johns Hopkins University are in accord with our ultimate objective. We hope that we can be reassured that this is so.

Sincerely,
Robert vL. Campbell, M.D.
President

*See page 40 for full text of report.



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

Supplemental Report of the Laboratory Services Subcommittee to the Liaison Committee, Dealing with Blood Banking

THE NATURE OF BLOOD BANKING

From the selection and bleeding of a donor to the administration of his blood as a transfusion, the two main pertinent processes comprise: (1) blood banking—obtaining the blood and its storage, processing, and issue; and (2) transfusion service—its selection, preparation for, and administration to an individual person. These two processes may occur either in close proximity both in time and place, or at great distances in place, variable but limited separation in time. This report takes into consideration, primarily, the first of these processes, blood banking. Blood banks are of three general classifications: hospital, community, and commercial.

PROFESSIONAL MEDICAL INTEREST AND RESPONSIBILITY

The attending physician holds uppermost in mind the welfare of his patient. Individually, it is impossible for him to take precautions that blood transfused on his orders is reasonably safe from harming the patient. These precautions can be undertaken through the collective expression of professional ethics incumbent upon his fellow physicians. This concept involves a series of professional responsibilities. The potential harmful effects of transfused blood are so varied that the selection of donors and all subsequent steps must be retained under ethical, medical professional supervision. It is on the basis of these considerations that professional associations have issued statements of policies and principles as follows:

(1) American Association of Blood Banks

Standards for a Blood Transfusion Service, Fourth Edition, 1964

A. All phases of the selection of blood donors and of the collection, storage, processing and transfusion of blood shall be the responsibility of a qualified, licensed physician with a thorough knowledge of blood bank methods and of transfusion principles and practices . . .

(2) College of American Pathologists, 1964 Directory

Statement of Principles Relating to the Practice of Pathology

1. Whereas, The Practice of Pathology is defined as pathologic anatomy and clinical pathology, including such subdivisions as clinical chemistry, clinical microbiology, hematology, diagnostic radioisotopes, exfoliative cytology, blood banking, clinical microscopy, and other related disciplines, and

2. Whereas, Pathology is recognized as the practice of medicine by statutes of various states, courts of law, and organizations such as the American Medical Association and the College of American Pathologists . . . Therefore be it

1. *Resolved,* That contracts or agreements between pathologists and institutions must be in accord with the requirements of law and with the codes of ethics and statements of principles of the American Medical Association and of the College of American Pathologists; and be it further

2. *Resolved,* That such contracts or agreements must preclude the sale of the services of a pathologist by institutions, organizations or nonmedical persons, for a fee; . . .

(3) American Medical Association, Judicial Council Opinions and Reports, 1964. Section 6.

RELATION OF PHYSICIANS AND HOSPITALS

"A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the service of that physician by such agency for a fee . . .

PRACTICAL CONSIDERATIONS

The quantities of blood required for transfusion have greatly increased in recent years because of the development of techniques for surgery of the heart, blood vessels, and respiratory organs, the

Adopted by the Council June 17, 1965.



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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care of acute injuries, and for other therapeutic purposes. Increased knowledge of the hazards of transfusion have tended to limit the use of transfused blood, but further knowledge in this field and its dissemination and application are needed. Nevertheless, demands for increased amounts of blood for transfusion are expected. To meet these demands, if the medical profession should take the attitude that blood for transfusion is a commodity rather than a professional service, commercial enterprises can be expected to undertake, as has already been started, the procurement and banking of blood as a profit-making endeavor. Unless ethical, medical supervision can be maintained over all aspects of blood banking, the reliance by attending physicians on blood for transfusion is unsound. Therefore, your committee believes that every blood bank of any type must operate only under full authority of an ethical, licensed physician, who is, thereby, professionally responsible. The arrangements for his remuneration should be such as to preclude his providing medical services for the profit of a non-medical agency.

CONCLUSIONS

In order to attain optimum standards of medical care, your subcommittee recommends the adoption of the following principles:

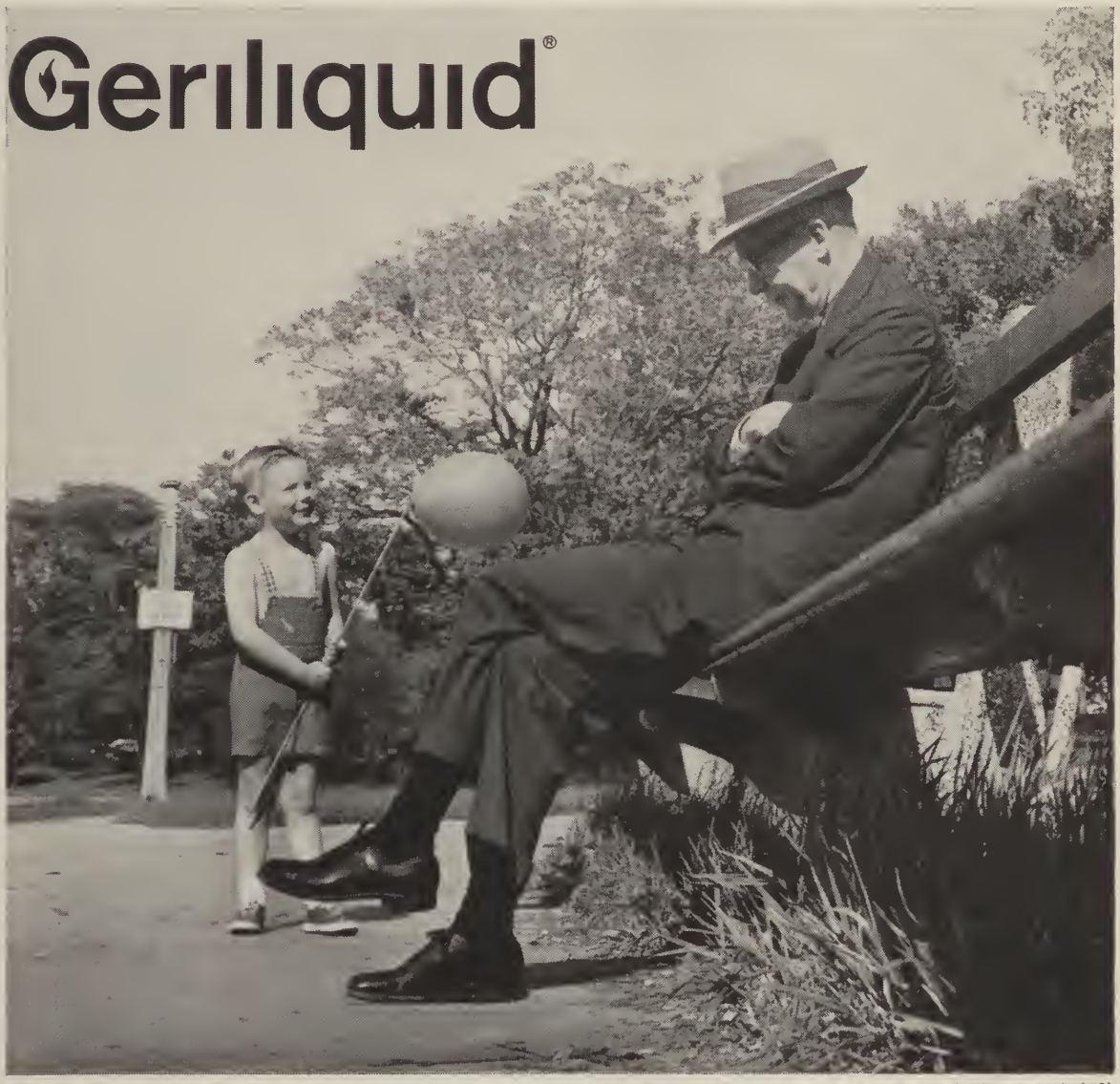
1. The practice of blood banking constitutes the practice of medicine requiring full supervisory authority and responsibility of a licensed physician.
2. Any physician who allows his name and professional status to be used by a non-commercial blood banking agency without first assuring himself that he has full professional authority over the operations of the agency, and without actually assuming the professional responsibility for the products of the agency, is to be considered in unethical practice until it is otherwise demonstrated.
3. It shall be unethical for any physician to allow his name and professional status to be used by or receive remuneration from any blood bank operated primarily as a commercial enterprise.
4. All licensed and registered physicians, particularly members of the Medical and Chirurgical Faculty of the State of Maryland, should encourage and support ethical agencies for the provision of blood for transfusion, in order to guide, under medical supervision rather than commercial or non-medical supervision, the provision of the amounts of blood necessary for proper medical care.

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provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

Report of the Laboratory Services Subcommittee to the Liaison Committee

On May 28, 1964, the Liaison Committee established the Laboratory Services Subcommittee to "consider laboratory services as they related to the general public health and requirements of the people of Maryland."

Three meetings of the subcommittee have been held and a letter addressed to all state health departments in the United States, asking for information with respect to the operation of clinical laboratories in their state. The response to our query was very gratifying but, in general, most states seemed to have little regulation except for serology tests. In view of this the subcommittee was of the opinion that it must develop its own ideas in this area.

GUIDES FOR ETHICAL CONDUCT

The Subcommittee feels that with the full cooperation of the medical profession and others concerned a program can be maintained in Maryland obviating the need for legislation to enforce rules which basically call for ethical conduct. The medical profession has guides for the development of such a program in the *Opinions and Reports of the Judicial Council of the American Medical Association.* The tenets of this document, subscribed to by all medical societies in the United States, basically point out that an unearned addition to a fee for a laboratory test constitutes an unethical practice and further suggest that direct billing by all who render service is the most desirable method.

The first recommendation of the Subcommittee is that all component societies of the Faculty thoroughly review the aforementioned document, that such a review be held in a regular meeting of the medical societies for all members, and that these recommendations be published in the Maryland State Medical Journal.

CLINICAL LABORATORIES

It is recognized that clinical laboratories both in and out of Maryland perform tests for Maryland patients. It is the feeling of the Subcommittee that adequate supervision by competently trained individuals is necessary in every laboratory.

The best interests of the patient are uppermost in the physician's mind; therefore, the laboratories best equipped, both with personnel and equipment, should be used to perform the tests needed. The necessity for the highest quality of work in performing laboratory tests is without question. It is the feeling of the subcommittee that all physicians should assure themselves that the tests being performed for their patients meet the highest standards. By education of the medical profession and other disciplines involved, it is felt that any laboratories now doing substandard work would be forced to meet the demands of the public by providing higher quality work.

LABORATORIES IN PHYSICIANS' OFFICES

The subcommittee recognizes that certain physicians maintain laboratories in their offices for the convenience of their patients. This statement in no way reflects negatively on this practice. These laboratories should maintain the same high quality of performance, and the recommendations are equally applicable to them as to all physicians.

EDUCATION

It is the recommendation of this subcommittee that all disciplines concerned with this matter establish a program of education of its members regarding an ethical program based on the tenets of the *Opinions and Reports of the Judicial Council of the American Medical Association,* which interprets in detail the *Principles of Medical Ethics of the AMA.*

Such a program should include the material contained in this subcommittee report which supplements to a certain degree these Principles.

BILLING

A contractual agreement between the laboratory and the physician is not in the best interests of the patient. The absence of a contract will eliminate the possibility of a conflict of interest for the physician. In addition, such an agreement makes it difficult, if not impossible, to conform to the principles of direct billing, since a true cost cannot be determined for a specific test under a contract which allows a sliding scale of fees depending on the volume of tests performed.

CONCLUSIONS

In order that the highest standards of work

Adopted by the Council June 17, 1965.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



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be performed in clinical laboratories in Maryland and that the highest quality of laboratory services be made available to the citizens of Maryland, the subcommittee recommends that the following guidelines be established:

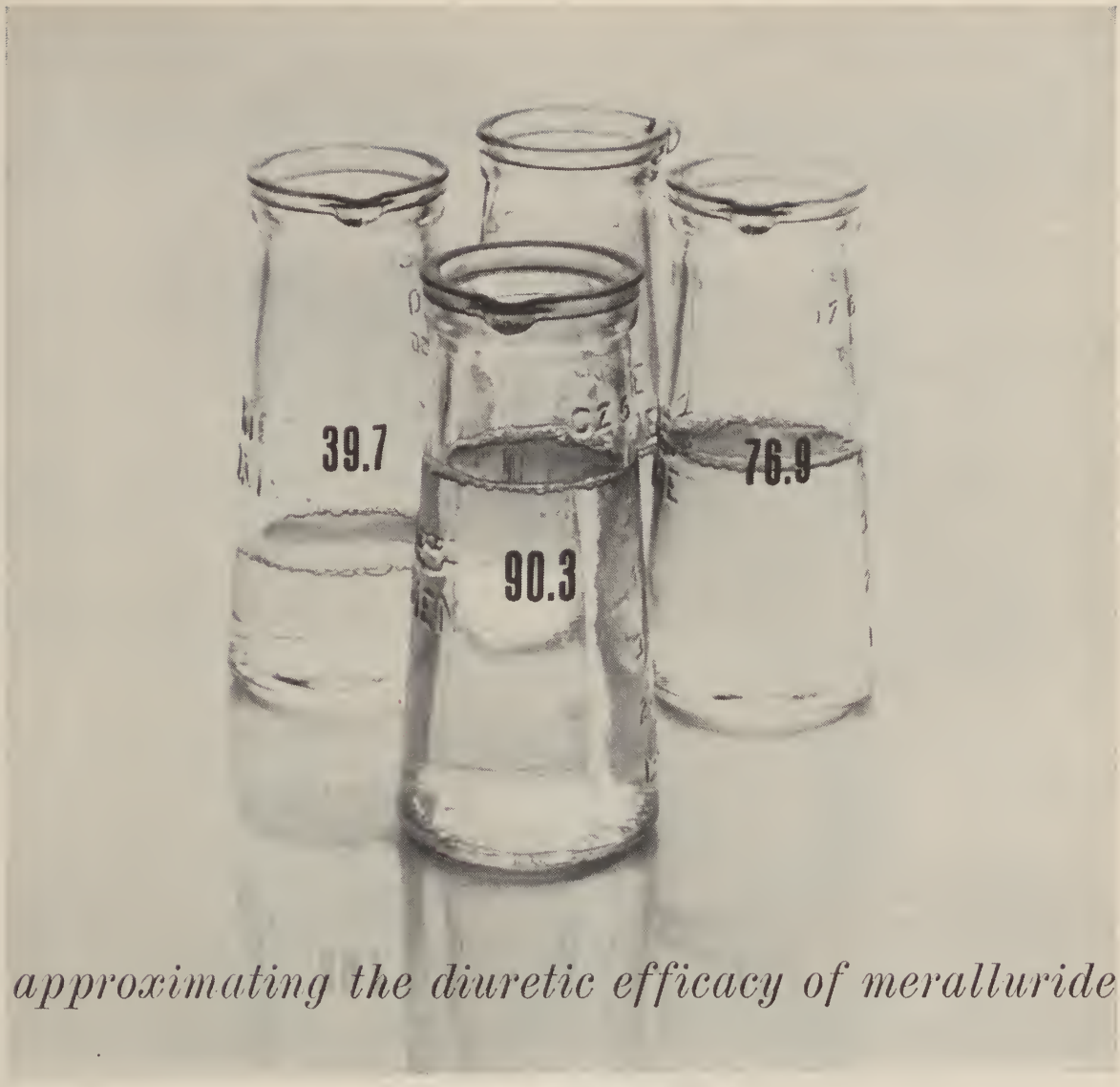
1. Laboratory medicine is the Practice of Medicine and should be practiced only in laboratories owned (except in licensed hospitals and governmental facilities), operated and professionally adequately supervised by licensed and registered physicians.
2. It shall be considered proper for a physician to send to any other physician of his choosing an announcement that he has opened an office, changed the location of an office or changed the professional composition of his office for the practice of medicine, in the format approved by the Medical and Chirurgical Faculty. Return forms that serve only to facilitate the communication between the interested physician and laboratory but do not in themselves give specific information, such as fees, office hours, special qualifications, other than membership in professional Boards or Societies, are acceptable. Fee schedules and other specific information material may be sent only to those physicians who request them or who *regularly utilize* the facilities of the laboratory.
3. It shall be considered unethical for:
   (a) A lay employee, directly or indirectly, to solicit work from physicians.
   (b) To advertise laboratory services in any media such as magazines, journals, newspapers, etc.
   (c) To display any advertising material on vehicles.
   (d) To distribute mailing containers except on request.
4. Whenever any physician collects fees for laboratory services which are not performed by him or his regularly employed assistants, the opportunity exists for him to split the fees and to receive income to which he is not entitled; therefore, all billing should be done by the laboratory billing the service.
   If a clinician and a laboratory share the responsibility for a laboratory procedure, each should send a bill for services rendered. No physician should be denied a reasonable fee for obtaining a specimen for testing purposes and/or interpreting the results of the test, but this should be itemized separately and appear on the physician's statement.
5. It shall be considered unethical for any physician to:
   (a) Submit specimens to any laboratories not owned (except in licensed hospitals and governmental facilities), operated and professionally adequately supervised by a licensed and registered physician.
   (b) Bill for laboratory services not performed by him or his regularly supervised employed assistants.
   (c) Send specimens to any laboratory rendering laboratory services at a flat fee (so-called contractual agreements).
   (d) Share income from laboratory services directly or indirectly with any lay person.
   (e) Offer laboratory services under a fictitious name.
   (f) Offer laboratory services for the care of patients as a corporate structure.
   (g) Have a financial interest in any clinical laboratory where the physician is not personally and professionally responsible for the quality of the work performed in the laboratory.
   (h) Collect fees from any insurance company for laboratory services not performed by him or his regularly employed assistants.
6. The subcommittee also recommends that, with the approval of the Liaison Committee, these recommendations involving the question of professional ethics should be submitted to the Faculty's Mediation Committee for endorsement and approval and final submission to the Council for its approval as Faculty policy.

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To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice Act

Discussion took place on procedures now performed by nurses and the desirability of their being in scope of practice of medicine and still being practiced by registered nurses, under the order of a licensed, registered physician who assumes full responsibility for the act. Specific permissions and restrictions may be made by the local medical staff in each hospital in the state. Generally, if the act performed by the registered nurse is basically mechanical, not requiring the exercise of medical judgment, and is done by order of or supervision by a physician, it is legal.

The following suggestions were made on the items listed, provided by the Maryland Nurses Association:

1. **Initiation of external cardiopulmonary resuscitation and artificial respiration (mouth-to-mouth or mouth-to-nose)**

This would be done as a first-aid measure, and any person adequately trained and accepted as qualified to do it would normally proceed with such action. Nurses should have a training program for the persons who perform this service. They should also be taught protective measures in training to prevent contracting a disease such as tuberculosis, syphilis or meningitis.

2. **Administration of investigational drugs**

This would be done on orders of a physician, with permission of the patient (consent form), and approval of the medical advisory committee or board at the hospitals.

3. **Administration of subcutaneous infusions**

Approved administration by nurse, with orders of a physician.

4. **Vena puncture**

Approved administration by nurse, with orders of a physician.

5. **Administration of intravenous a) Fluids, b) Blood, c) Medications, d) Medications added to fluids**

Approved administration by Intensive Care Unit IV or Fluid Team; blood given with physician, preferably a pathologist, supervision.

6. **Removal of inter-cath (indwelling intravenous catheter)**

Approved administration by nurse.

7. **Deep intratracheal suction**

No, should be anesthesiologist or anesthetist under the direction of anesthesiologist.

8. **Administration of anesthesia during labor**

No, should be anesthesiologist or anesthetist under the direction of anesthesiologist.

9. **Vaginal examination during labor**

Approved on order of physician.

10. **Rectal examination during labor**

Approved on order of physician.

11. **Removal of sutures**

Approved on order of physician.

12. **Suture of minor lacerations**

No—unqualified.

Adopted by the Council, June 17, 1965.
See statement by Maryland Nurses Association, page 144.

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

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13. Exchange fluids in peritoneal dialysis

Qualified yes.

14. Performance of tracheotomy

No—unqualified.

15. Insertion of gastric tubes

Approved.

16. "Milking" chest tubes to keep them open

Approved.

17. Interpretation of electrocardiograms

No—unqualified.

18. Substitute for the pharmacist in his absence

Approved, if no compounding of Rx.

19. Application of pressure bandages to control hemorrhage

Approved.

20. Operation of intermittent positive pressure machine

Approved, if properly trained.

NURSING LIAISON SUBCOMMITTEE: John F. Schaefer, MD, chairman; Charles P. Crimy, MD, W. Kenneth Mansfield, MD, M. Ruth Moubray, RN, Frances D. Tompkins, RN, Eleaner A. Zink, RN.

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

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Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

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IN BRIEF:

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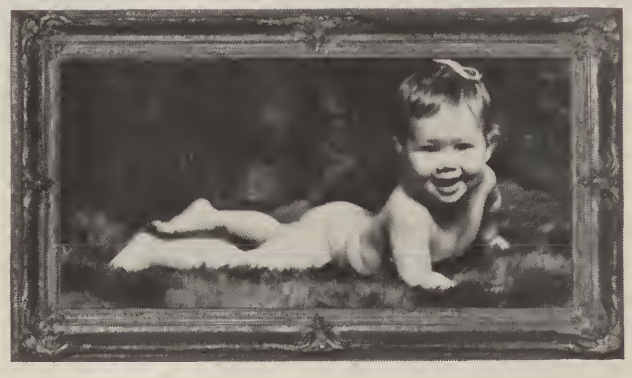
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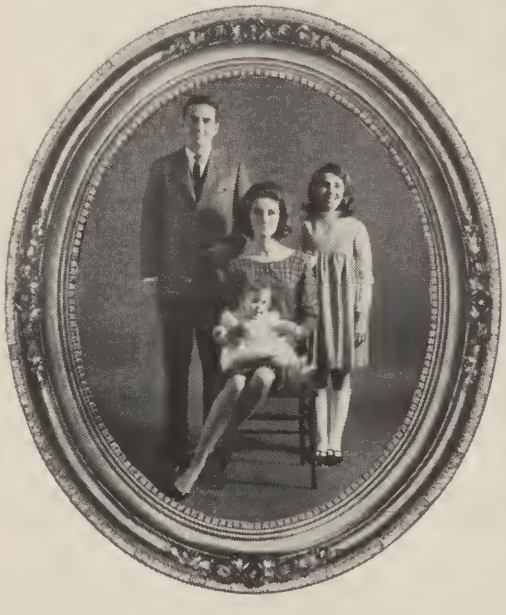
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. 8:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

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Use of Term Medical Center or Medical Clinic

The committee was of the opinion that the terms *medical center* and *medical clinic* brings a wide difference of opinion as to their meaning. In the instance of the term *medical center,* it felt that this was of no real significance and that no formal action was necessary insofar as designation of what constitutes a medical center.

The use of the term *medical clinic* also brought forth a wide divergence of opinion as to its meaning. The committee, therefore, is of the opinion that some definition should be provided to members of the Faculty for their guidance. The committee recommends that the definition of *medical clinic* as defined by the AMA be used and that this use be disseminated to the Faculty members for their information. This definition is as follows:

DIAGNOSTIC CLINIC

The name "clinic," because of its association with the earlier uses of the term, implies a very superior service by very superior individuals. This is frequently not the case. If the American Medical Association is to define a diagnostic clinic, it must be done in a way that will represent the efficiency that modern scientific progress has made possible to the doctor of medicine who has kept abreast of that progress and the idealism or ethical principles that for hundreds of years have been our most cherished heritage as a profession. The Council submits the following as its opinion of a proper definition of a diagnostic clinic:

(1) A diagnostic clinic is an organization of physicians whose sole work in the clinic is to make or supervise diagnostic examinations of patients referred to the clinic by doctors of medicine, or to collaborate in general diagnostic surveys.

(2) The reports of the diagnostic clinic on examinations and tests are made only to the referring physician unless he requests that the case and the recommendations for treatment be discussed with the patient as a part of a professional consultation at which the relationship of the results of the diagnostic studies to the general condition of the patient is open for discussion. In such case, discussion is only by a member of the staff.

(3) The staff of the diagnostic clinic should include representatives from all the specialties that are of recognized diagnostic usefulness. Every clinical examination, laboratory test or X-ray procedure is made by a physician who specializes in that field or under his supervision. The clinic must be equipped to allow the various specialists to exercise fully their abilities.

(4) The control of the clinic must be vested in one or more members of the professional staff. Any profits are to be apportioned only to the members of the staff actually engaged in the work of the clinic. There must be no dividends, bonuses or salaries paid any individual except for services rendered.

(5) The clinic must be governed in its activities by the same ethical principles as apply to any individual member of the American Medical Association.

It is recognized that under this definition only in cities large enough to support the various specialists needed can a diagnostic clinic be established or maintained. Unless the specialists are available it is not a diagnostic clinic worthy of the name. (AMA House of Delegates, 1939)

From report of the Policy and Planning Committee. Adopted by the Council, June 17, 1965.

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Modern Aspects of CERVICAL CANCER

A review of carcinoma-in-situ of the cervix, pointing out the criteria for the diagnosis, showing its relation to invasive cancer, and outlining rational therapy. By means of cytology, an understanding of carcinoma-in-situ, and the cooperation of the doctors and the women of this country, invasive cervical cancer may be eradicated as a lethal disease.

RICHARD W. TELINDE, MD
Professor Emeritus of Gynecology, The Johns Hopkins University School of Medicine

IT IS A SPECIAL PLEASURE for me to give this lecture honoring the father of my friend, J. Mason Hundley. It is one thing to be asked to give a lecture by someone who knows you only by professional reputation; it is quite another thing to have the honor of being asked to give a lecture of this type by a lifelong friend who knows you both personally and professionally. It is a true compliment for which I am grateful to Dr. Mason Hundley. Dr. Hundley's father was a gynecologist of the old school, by which I mean he was outstanding in pelvic surgery, an art which unfortunately is not receiving its proper emphasis today in the training of gynecologists in many institutions. Dr. Hundley, Sr. held the chair of professor of gynecology at the University of Maryland from 1900 to 1927. His shoes were then ably filled by his son, who is with us today, from 1935 to 1955.

Dr. Hundley gave me my choice of subjects, and I chose the modern aspects of cervical cancer for two reasons:

1) Our knowledge of cytology and of carcinoma-in-situ constitutes one of the few major "breakthroughs" in the battle against cancer.

2) It is particularly appropriate to talk about this subject to a Maryland audience, for much work on cervical cancer in the early and latter years was done right here in Baltimore.

Twenty years ago the subject of cervical cancer was a pretty dull and discouraging one. The gross lesion was visualized, its nature proven by biopsy, and the woman was treated by irradiation. The five year salvage in the better institutions was about 25%. Now, with cytology and our understanding of carcinoma-in-situ, we can cure almost 100% of the cases detected in the preinvasive stage. I should like to take a few minutes to review the history of the preinvasive disease.

The first portrayal of carcinoma-in-situ in the world literature which I can discover is in Cullen's volume on *Cancer of the Uterus,* published in 1900. The picture is a drawing of cell changes in the surface epithelium around the periphery of an advanced cervical cancer. The original slide, made in 1894, is still in our laboratory; and in Cullen's book it is designated as suspicious cell changes in the epithelium surrounding the invasive lesion. In 1910, Isador Rubin reported two cases which he

The J. Mason Hundley Annual Lecture in Gynecology, delivered April 22, 1965, before the Medical and Chirurgical Faculty of the State of Maryland.

designated as "incipient carcinoma." We now recognize these cases as the condition which we call carcinoma-in-situ. In 1912, Schottlander and Kermauner described the same microscopic picture around the periphery of invasive cancer, and they considered it a method of spread of invasive cancer. It was not until Schiller, in the 1930's, conceived the idea that possibly the intra-epithelial lesion was often a forerunner of invasive cancer that the true nature of the lesion was suspected. He produced some evidence to show that the in-situ lesion had a definite relation to invasive cancer, but his evidence was scanty. It was at this point, in the early '40's, that Gerald Galvin and I became interested in the subject and tried to solve three fundamental questions:

1) What are the minimal histologic changes in the surface epithelium necessary to justify a diagnosis of carcinoma-in-situ?

2) What is the relation between carcinoma-in-situ and invasive cervical cancer?

3) How should carcinoma-in-situ be treated? The answer to the third question obviously depends on the answer to the second, for if there is no relationship the condition is of no importance. If the in-situ lesion is a forerunner of the invasive lesion, its correct treatment is all important.

Before answering these questions I would like to say a few words about present day cytology in relation to carcinoma-in-situ, for it is through cytology that the first hint of the existence of the in-situ lesion is obtained in almost all cases.

You will notice that in speaking of our understanding of early cancer detection I mention both cytology and carcinoma-in-situ. Both of these are complementary to each other. If we had only cytology and did not know how to interpret the biopsy finding when the lesion is in the preinvasive state, there would be little practical value in cytology. On the other hand, if we did not have cytology and were required to detect carcinoma-in-situ from biopsying normal looking cervices, very few cases of microscopic cancer would be discovered.

Cytology as practiced by smearing the cervix and the vaginal vault has become a routine procedure in gynecologists' and many practitioners' offices. I should, in passing, like to mention the work which is now being done in this state by Dr. Hugh Davis for the Maryland Division of the American Cancer Society on what might be called a do-it-yourself basis. This experiment has been carried out in Washington, Frederick, Kent, and Carroll counties, and is currently being done in Anne Arundel county. A kit containing a syringe, a solution for lavage of the vagina, and a suitable fixative is sent to the women in these counties between the ages of 30 and 45. The resulting washings are forwarded by mail to Dr. Davis, who smears the centrifugalized sediment and processes them through the cytology laboratory. He tells me that smears made in this manner are far superior to the usual smear taken directly from the cervix or vaginal vault. When a positive smear is found, the patient is contacted and advised to have the proper examinations to establish a diagnosis.

The question naturally arises as to how effective this method is as compared to the detection clinics set up by the Maryland Division of the American Cancer Society several years ago. The examination in the detection centers included a bimanual pelvic examination, four quadrant cervical biopsies, and a smear. There was a yield of 6.8 cancers per 1,000 women from the detection centers, and Dr. Davis is finding a yield of 7.2 per thousand from the do-it-yourself study. From these figures I do not mean to conclude that the bimanual examination is unnecessary, for it is necessary to determine the presence of ovarian growths; but the figures do illustrate that the do-it-yourself method is equally effective in detecting clinical cancer.

Regardless of the method of taking the smears, almost all cases of early cervical cancer are detected today by smears. I would now like to move on to the second phase of early detection, namely, the subject of carcinoma-in-situ.

I shall attempt to answer the first question which I have proposed concerning the histologic picture of carcinoma-in-situ. Figure 1 is a typical example of carcinoma-in-situ. You will note that there is none of the normal stratification from the basalis layer, through the transitional layer, and finally the superficial layer of spinal cells such as one sees in the normal cervical epithelium. The stratified cells are replaced by cells with hyperchromatic nuclei and many mitoses. After careful study we have concluded that the full thickness of the surface epithelium must be taken over by these abnormal cells in order to justify the diagnosis. One encounters many cases in which only the basal cells of the surface epithelium show these

changes. In other cases the hyperactive cells extend through more of the epithelium but not through its full thickness. We have refused to concede that this picture is carcinoma-in-situ. Our opinion is based on our follow-up study of such cases with repeated biopsies. From this study it appears that such hyperactivity may regress; but the greater the degree to which the epithelium is involved, the more likely is true carcinoma-in-situ to ultimately be diagnosed. In practical words, when one receives a pathologic diagnosis of basal cell hyperactivity, the case should be followed until subsequent biopsies show normal epithelium and the cytology smear is negative or until the typical picture of carcinoma-in-situ is found. I have elaborated on this because, in our opinion, the diagnosis of in-situ cancer is still made too lightly in some clinics.

Let us now consider the second question, namely, the relation of carcinoma-in-situ to invasive cancer. This is obviously the crux of the whole question. Dr. Galvin and I directed our attention

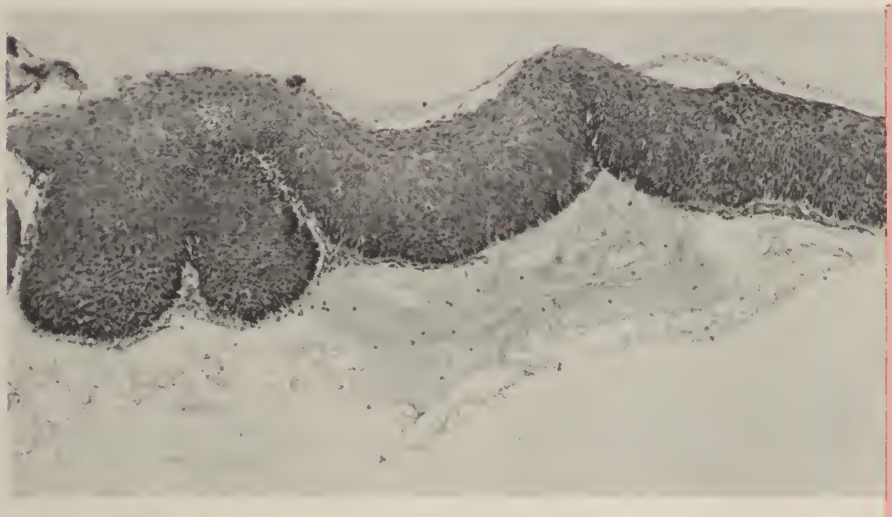


Fig. 1
Typical carcinoma-in-situ. The atypical cells with hyperchromatic nuclei are present through the full thickness of the epithelium.

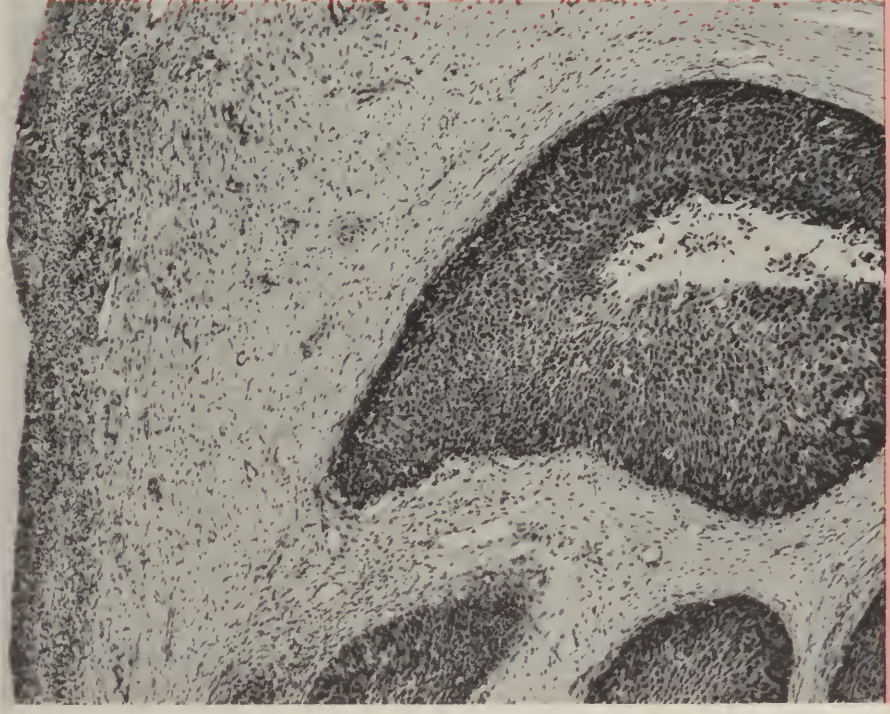


Fig. 2
Glands filled with malignant looking cells. The glands are greatly increased in diameter due to the growth of the malignant cells.

to this some 20 years ago. In those precytology days we worked entirely with biopsies. The cervix of every patient who was scheduled for hysterectomy for supposed benign disease was biopsied. In a small percentage of these, the microscopic picture which we now call carcinoma-in-situ was found. After the hysterectomy the cervix was cut into several blocks and many sections made from each block. Out of a total of 108 cases in which the surface epithelium was involved, there were 72 in which the same malignant looking cells were found beneath the surface epithelium, either in the lumina of the glands or in the stroma. The filling of the glands with these malignant looking cells does not constitute true invasion, but it is not exactly equivalent to the filling of the gland with cells in epidermidization. In the latter case, when the lumen of the gland is full, growth ceases. When the gland is filled with these malignant looking cells, growth continues, often until the mass of tissue is many times the normal diameter of the lumen (fig 2).

Although the microscopic findings of the removed uteri often suggested a potentially invasive lesion, it was not conclusive. Therefore, at a later date, Drs. Jones, Galvin, and I made a retrospective study of our cases of invasive cervical cancer. There were 723 cases of invasive cancer treated in our clinic over a period of 11 years. Among them there were 13 cases in which biopsies had been taken in our clinic from one to 17 years before. We reviewed these microscopic slides and cut more sections from the blocks. In one case there was no epithelium, leaving 12 in which we could study the epithelium. Of the 12 cases, 11 showed definite carcinoma-in-situ, a percentage far too great to be a coincidence. From these studies we have concluded that invasive cervical cancer is often preceded by carcinoma-in-situ, often by many years. Perhaps it is always preceded by preinvasive cancer, but no one is licensed to make this statement, and I doubt if this can ever be proved. Nor do we maintain that all cases of carcinoma-in-situ eventually become invasive cancer. Obviously they do not, for many women will die of other causes before the invasive lesion develops.

Let us now consider the question from a practical point of view. The most important question is concerned with what the clinician should do upon receiving a report of a positive or suspicious smear from the cytopathologist. The first thing to remember is that such a report does not constitute an emergency and that even a Class V smear is not an indication for a hysterectomy without further study. According to the cytopathologists, a Class V smear means unequivocal cancer, and in my experience this is true. A Class IV smear means almost certainly cancer, and a Class III smear may mean cancer. The problem which confronts the gynecologist at this point is to determine if cancer exists, where it exists, what type of cancer is present, and in what stage. The importance of this lies in the fact that correct therapy can be instituted only after these questions have been answered.

First let us consider the report of a Class III or suspicious smear. The next step should be to take another smear. If this proves to be a Class I or II, there is no need to go ahead with further investigation immediately. A third smear may be taken in two or three months, and if this is negative, the patient may be put on an annual checkup basis like any other patient. If the third smear is reported as III, IV, or V, further investigation is carried out.

The next procedure after a definitely positive smear should be a Schiller test with iodine, which will often give valuable information regarding the extent of the lesion on the surface of the cervix and regarding involvement of the vagina. The importance of this is obvious when we see that almost all recurrences which we have had have been in the vaginal vault, indicating that insufficient vaginal cuff was removed at the hysterectomy. Also, the Schiller test constitutes a good guide as to where to take the biopsy. The non-stained areas should be biopsied, and several pieces of tissue around the external os and from within the cervical canal should also be taken. In taking a biopsy one should bear in mind that the pathologist can only give you an opinion on the tissue which he has under the microscope.

The question is sometimes asked, "Why biopsy rather than go directly to conization?" There are two good reasons. The biopsies may show definite invasive cancer, in which case the lesion is classified as Stage I and treated with irradiation. Irradiation is carried out much better on the cervix which has not been coned. There is more substance to the cervix to protect the paracervical region. We found that postirradiation complica-

tions, especially parametrial infections, were much more frequent and severe in the conized cases. Also, the small postmenopausal cervix does not lend itself to conization. If a reasonably extensive conization is done, nothing is left but a rim of cervical tissue to which it is difficult to apply radium satisfactorily in case invasive cancer is found. If one does a superficial conization on such a small cervix, it has little if any advantage over multiple biopsies. However, if the repeated smears are positive and the biopsies negative, conization is definitely indicated regardless of the size of the cervix. When conization is done, a curettement of the uterine cavity should be performed under the same anesthetic but after the cone is taken. Also, if biopsies show equivocal invasive cancer or equivocal carcinoma-in-situ, a cone should be taken.

THERAPY

When Dr. Galvin and I first began our study of this condition, we did it upon patients who were scheduled for hysterectomy for benign disease. Therefore, in these cases the treatment was automatically total abdominal hysterectomy. Most of these patients remained free from recurrent carcinoma. There have been, however, among our series of more than 500 cases of this disease 10 recurrences, some with carcinoma-in-situ and some with invasive cancer. If further proof of the relationship between preinvasive and invasive cancer is necessary, these recurrences supply the evidence.

The operation which we have done mostly in the past several years has been modified somewhat from the simple total hysterectomy, a cuff of vaginal mucosa being removed with the cervix. The size of this cuff may be determined to some extent by the results of the Schiller test. Also, about an inch of parametrium is removed with the cervix. This is easily accomplished by passing ureteral catheters preoperatively so that the ureters can be identified at all times during the operation without dissecting them out.

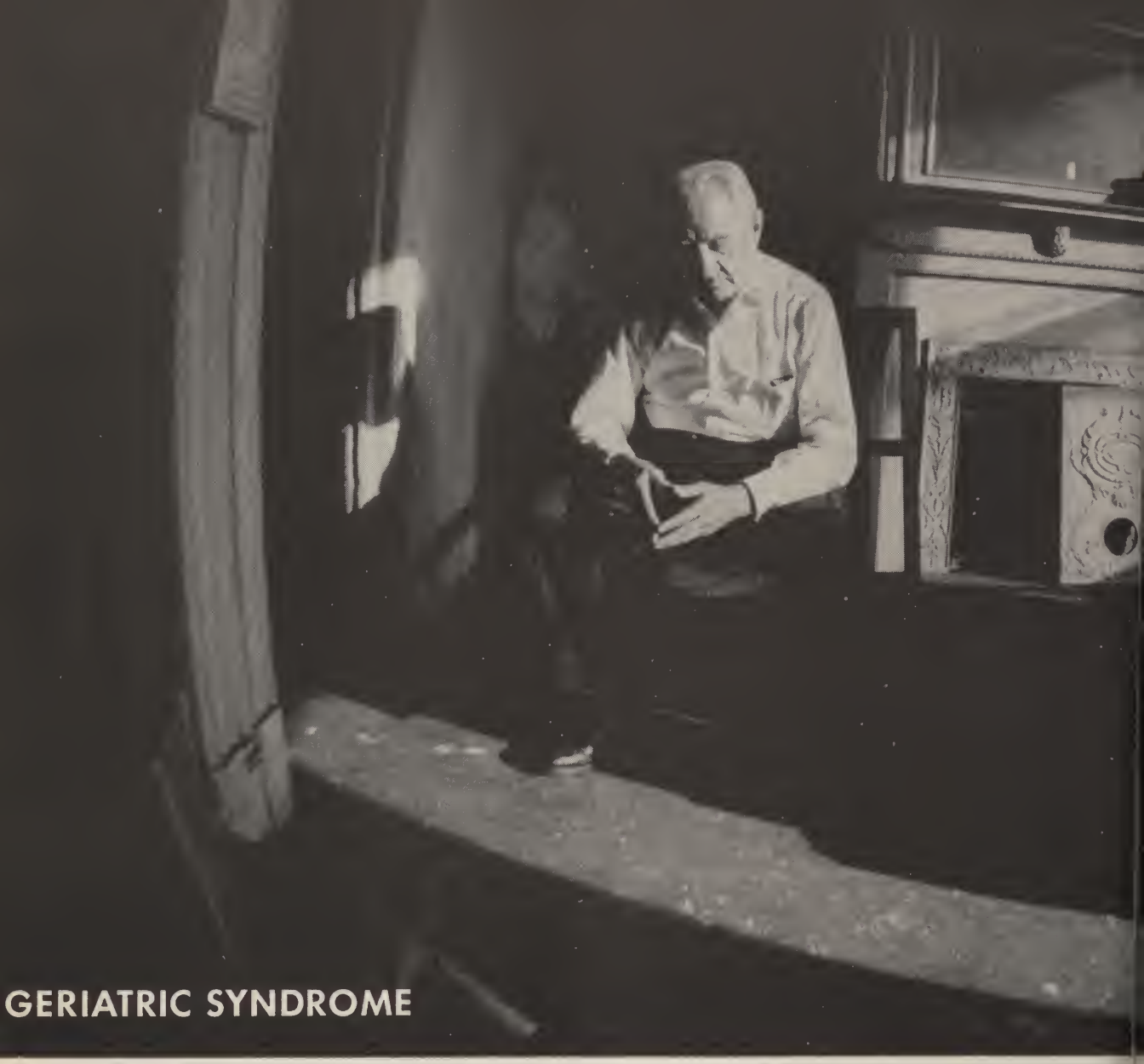
Some operators have preferred vaginal hysterectomy, and one can remove a good vaginal cuff easily by this route. We have used this method on occasion in excessively obese women, very old women, and in some associated with prolapse and marked vaginal relaxation. Although the vaginal operation offers the advantage of easily obtaining an adequate cuff, it has the disadvantage of not being able to explore the pelvis for lymph node involvement. However, this occurs rarely when, in spite of conization, the case has been misjudged and invasive cancer exists. Since this occurred only twice in our series of more than 500 cases, the choice of approach may be left up to the surgeon without strong prejudice either way.

When rather marked but still microscopic stromal invasion is found in the coned specimen, the case is considered as Stage I and treated by irradiation. When there is minimal stromal invasion the cases cannot theoretically be classified as in-situ, but we have treated them with hysterectomy exactly as the noninvasive lesions with equally good results.

One may naturally ask, "Why not treat these women with irradiation since the cures with irradiation in Stage I are 75-85%?" One answer is that most of these women are young; the average age of our patients was 37 years. Irradiation means artificial menopause with its attending hot flushes, nervous instability, contracted vagina, and often resulting dyspareunia. With surgery we have removed or spared ovaries on exactly the same indications as when doing hysterectomy for benign disease. The ovary is a place of late metastasis even in advanced cervical cancer, and we have never seen it in any cases in this group. The results have been just as satisfactory in the patients in whom ovaries were spared as in the others.

What have been our ultimate results? As stated, in more than 500 cases treated by hysterectomy there have been 10 recurrences, all in the vaginal vault. The recurrences have been treated by irradiation or vaginectomy. Seven are well, and three have died of recurrent carcinoma. There were eight patients treated primarily by irradiation because they were poor operative risks. One of these died, and autopsy showed metastatic cancer.

It is obvious from our results with hysterectomy that the treatment has been successful. The question arises whether we have been unnecessarily radical surgically. There are those who advocate lesser procedures, such as cervical amputation, conization, and even cauterization. The possibility of such treatment should be seriously considered because some of these women are in the third decade of life and want more children. However,



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Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intraarteriolly. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

in one reported series of 41 cases, in which the women were treated by a method less than hysterectomy, 14 required further treatment for cervical cancer. We believe that this percentage is too great to justify the more conservative treatment as a routine.

When the disease occurs in young women who have had no children or who are anxious to have more, we tell them in layman's language the nature of the condition. We tell them that this is not cancer in the usual sense of the word, but we also emphasize that most invasive cancer is, to the best of our knowledge, preceded by this preinvasive lesion. We tell them that this transformation may take years, but we do not know how long. We do not tell them that invasive cancer is inevitable because we do not know this to be a fact. Thus far, all of our patients have chosen to have the hysterectomy rather than defer definitive treatment until another pregnancy or two.

When discovered during pregnancy, we do not believe it is an indication for hysterectomy until after the termination of the pregnancy; nor do we believe that a cesarean delivery is necessary. We are not enthusiastic about conization during pregnancy. In the third trimester of pregnancy, I believe it is absolutely contraindicated. Sufficient information can be gotten more safely by multiple biopsies. After the termination of the pregnancy the case is re-evaluated and treated by hysterectomy. We re-evaluate the case by means of smears, biopsies, and, in some instances, a cone; but in all cases in which an unequivocal diagnosis of cervical cancer was made during pregnancy, the diagnosis was verified after the pregnancy.

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Baltimore, Md. 21201

WHEN YOUR PATIENTS NEED
NURSING CARE

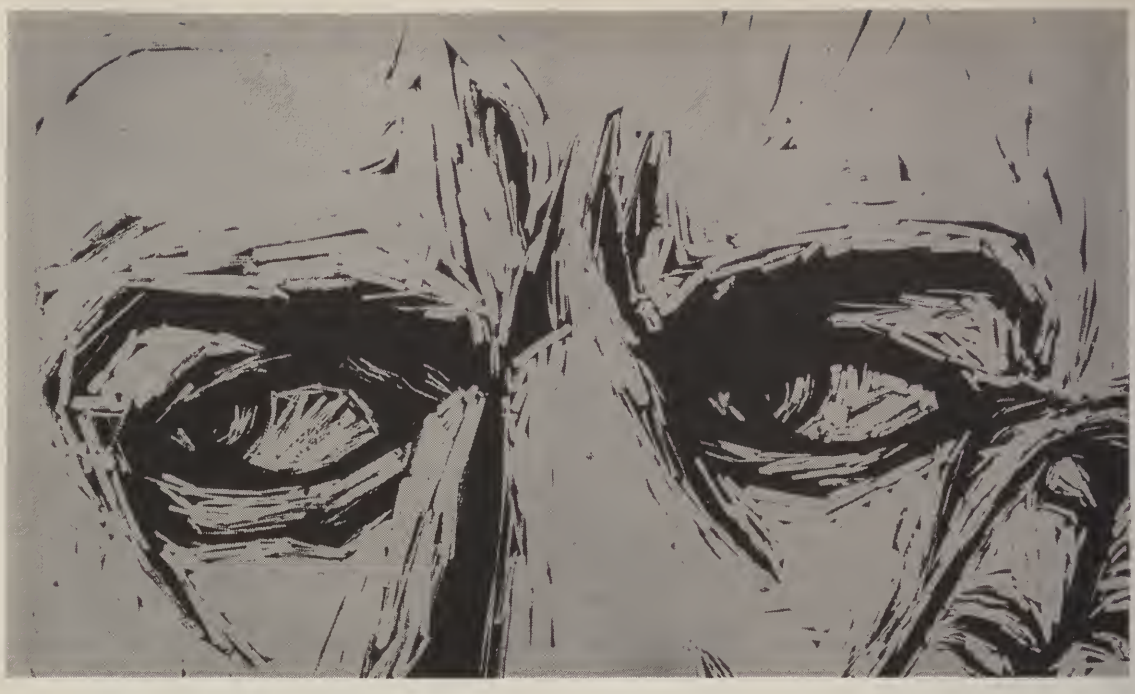


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Program of

OCEAN CITY MEETING

(Semiannual)

Headquarters

COMMANDER HOTEL

CEAN CITY, MARYLAND

FRIDAY

SEPTEMBER 10

1965

COMMANDER HOTEL
FRIDAY, SEPTEMBER 10

REGISTRATION—9:00 a.m., Lobby

Those who arrive on Thursday, September 9, may register that evening, 7:30 to 9:30 p.m.

ALL MEMBERS AND THEIR GUESTS ARE REQUESTED TO REGISTER

No registration fee

BUSINESS SESSIONS

Beach Lounge, Ground Floor

COUNCIL MEETING

Thursday, September 9, 8:30 p.m.

HOUSE OF DELEGATES

Friday, September 10, 9:30 a.m.

ALL members of the Faculty are invited to attend the meetings of the House of Delegates, but privileges of the floor are for delegates only.

Committee on Program and Arrangements

John Collins Harvey, M.D., *Chairman*, James B. Brooks, M.D., Thaddeus E. Prout, M.D., and Joseph D. B. King, M.D.

ADDITIONAL SCIENTIFIC SESSIONS

SATURDAY, SEPTEMBER 11

Commander Hotel

9:30 a.m. **Maryland Chapter, American College of Surgeons.** Beach Lounge.

Considerations in the Management of Undescended Testis. **Nicholas Mallis, M.D.**

Unusual Gastric Carcinomas. **Robert W. Buxton, M.D.**

Management of Disseminated Endometriosis. **Gerald A. Galvin, M.D.**

Management of Hemothorax. **William B. Long, M.D.**

Recent Medical Experiences in South Vietnam. **William H. Mosberg, Jr., M.D.**

9:30 a.m. **Maryland Psychiatric Society.** Social Room.

The Care of the Living Patient.
Allan R. McClary, M.D., Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine.

The Care of the Dying Patient.
Nathan Schnaper, M.D., Assistant Clinical Professor of Psychiatry, University of Maryland School of Medicine.

11:00 a.m. **Maryland Diabetes Association.** Social Room.

Dietary Treatment of Diabetes.
William R. Jordan, M.D., Associate Clinical Professor of Medicine, Medical College of Virginia.

SEE EXHIBIT IN SOCIAL ROOM, THURSDAY, FRIDAY, AND SATURDAY!

PLAN TO ATTEND THESE MEETINGS ALL PHYSICIANS INVITED

MEDICAL and CHIRURGICAL FACULTY of MD.

COMMANDER HOTEL
FRIDAY, SEPTEMBER 10
12:30 P.M.
Beach Lounge, Ground Floor

SCIENTIFIC SESSION

Words of Welcome

Robert vL. Campbell, M.D., *President*
Medical and Chirurgical Faculty

• • • • •

THE DOCTOR'S ROLE IN PHYSICAL FITNESS

ROBERT J. STEWART
ADMINISTRATOR
President's Council on Physical Fitness



Bob Stewart, former Director of Athletics at St. Louis University, was appointed Administrator of the President's Council on Physical Fitness on May 1, 1964. He heads the Council's four-man staff and is chief assistant to Stan Musial, Special Consultant to the President on Physical Fitness.

He has a wide background in the area of health, recreation, and physical education. Under his direction as athletic director of St. Louis University, the Billikens achieved their greatest athletic success. Mr. Stewart has coached and competed in professional basketball, playing in the old National Basketball League, later known as the New York State League. He has an advanced degree from the University of Rochester, is a four-year naval veteran, has had four years' business experience, plus experience in radio and TV, including play-by-play and color coverage of football and basketball games.

COMMANDER HOTEL
FRIDAY, SEPTEMBER 10

LUNCHEON
1:30 p.m. — Dining Room

• • • • •

COCKTAILS
and
DINNER DANCE

6:30 p.m. — Cocktails
Beach Lounge

7:30 p.m. — Dinner Dance
Dining Room

Cocktails will be included with dinner and setups will be available during and after dinner, but there is no provision at Hotel for sale of alcoholic beverages.

Dress optional

WOMAN'S AUXILIARY
Medical and Chirurgical Faculty
Mrs. Martin E. Strobel, *President*

FRIDAY, SEPTEMBER 10
Social Room, Commander Hotel

9:30 a.m. Coffee and Buns
10:00 a.m. Business Meeting

followed by

Speaker—**Roy E. Ritts, Jr., M.D.**
Director of Institute for
Biomedical Research—AMA-ERF

Film—"A Different Drum"

EVERYONE INVITED

1966 ANNUAL MEETING

April 27 and 28, Baltimore
April 29-May 4, Aboard Ship and in Bermuda

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DIABETES?

Testmobile outside Commander Hotel for those attending meeting.

September 9, 10, 11, 1965

BUSINESS SESSIONS

ANNUAL MEETING
April 21-23, 1965

MINUTES

The 249th meeting, first of the 167th Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, met at The Alcazar, Baltimore, Maryland, at 9:30 a.m., Wednesday, April 21, 1965, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors: *A. Andrew Alecce, Baltimore City; John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Henry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Council; Carlton Brinsfield, Council; Read N. Calvert, Montgomery County; Robert vL. Campbell, Council; Henry V. Chase, Council; Stuart M. Christhilf, Jr., Anne Arundel County; E. Paul Coffay, Jr., Baltimore City; Archie R. Cohen, Washington County; Ernest I. Cornbrooks, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; Louis C. Dobihal, Baltimore City; J. Sheldon Eastland, Council; William C. Ebeling, Council; Whitmer B. Firor, Past-President; Russell S. Fisher, Council; James P. Gallaher, Wicomico County; *Harold H. Gist, Washington County; Seymour Goldgraben, Cecil County; Albert E. Goldstein, Council; Edward G. Grau, Baltimore County; J. Roy Guyther, Council; William B. Hagan, Council; Thurston Harrison, Council; John C. Harvey, Baltimore City; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; William A. Holbrook, Prince George's County; James P. Jarboe, St. Mary's County; James R. Karns, Baltimore City; Lauriston L. Keown, Baltimore City; Howard F. Kinnamon, Past-President; Louis F. Klimes, Baltimore City; Louis Krause, Council; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Charles H. Ligon, Montgomery County; F. Ford Loker, Baltimore City; Charles R. MacDonald, Anne Arundel County; Howard B. Mays, Council; William J. McClafferty, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore City; *John A. Mitchell, Baltimore City; Frank K. Morris, Board of Medical Examiners; *Howard T. Morse, Montgomery County; Leslie L. Mould, Allegany County; George A. Moulton, Jr., Carroll County; William A. Pillsbury, Council; *Harold B. Plummer, Caroline County; J. Emmett Queen, Council; Jonas R. Rappeport, Baltimore County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Paul F. Richardson, Baltimore City; Eugene J. Riley, Baltimore City; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Edwin Ruzicka, Talbot County; Emmanuel Schimunek, Baltimore City; William B. Settle, Baltimore City; *Gordon M. Smith, Montgomery County; Aaron C. Sollod, Baltimore City; Omar D. Sprecher, Jr., Washington County; James E. Stoner, Jr., Frederick County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; F. J. Townsend, Worcester County; Aaron H. Traum, Montgomery County; Robert S. Turner, Jr., Frederick County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Hugh W. Ward, Calvert County; Lawrence R. Wharton, Jr., Baltimore City; J. Arthur Weinberg, Council; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Hans Wodak, Prince George's County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; Mr. Walter N. Kirkman, Catonsville.

Present also for the meeting were the following staff personnel: Messrs. John Sargeant and Joseph Harrison and Mrs. Anna Wynde Leake.

The President made several announcements concerning the transaction of business at the meeting and for informational purposes.

MINUTES

The minutes of the September 11, 1964, session; and the February 20, 1964, special session, having been approved by the Executive Committee and having been distributed to all delegates were presented to the House for information. They were amended as follows:

February 20, 1964, page 2, third paragraph, change name to read, "Donovan F. Ward," rather than "Hugh W. Ward" as shown.

VISITING MEDICAL SOCIETY PRESIDENTS

Albert C. Esposito, MD, President of the West Virginia State Medical Association; and Richard A. Kern, MD, President, Pennsylvania Medical Society; were introduced to the House and presented greetings from their respective organizations.

NECROLOGY

After the Secretary read the following names of deceased members, the House of Delegates members rose in observance of a moment's silence in respect for their deceased colleagues:

Baltimore City

Ayd, Frank J., Sr.	March 6, 1964
Blalock, Alfred	Sept. 15, 1964

Boyle, John Brooke, Jr.	Feb. 16, 1965
Chambers, Thomas R.	Sept. 6, 1964
Chesney, Alan M.	Sept. 22, 1964
Darby, William A.	Jan. 27, 1965
Ebeling, Karl W.	March 20, 1964
Edwards, C. Reid	Feb. 1, 1965
Goldberg, Sigmund	Jan. 22, 1965
Gordy, Lyle L.	March 22, 1965
Hyman, Calvin	Jan. 8, 1965
Jones, Benjamin F.	May 4, 1964
Kappelman, Melvin D.	Dec. 26, 1964
Katzenberger, James W.	March 5, 1964
Kimzey, Frederic J.	June 22, 1964
Knipp, George A.	Oct. 25, 1964
Koontz, Amos R.	Feb. 3, 1965
Michel, William	June 22, 1964
Moses, Bessie L.	March 25, 1965
Neustadt, John O.	Nov. 19, 1964
O'Donovan, Charles, Jr.	Sept. 22, 1964
Sacks, Milton S.	Oct. 3, 1964
Scheurich, John A.	June 16, 1964
Sheppard, Robert C.	April 26, 1964
Stout, Merrill L.	June 23, 1964
Walton, Henry J.	Jan. 24, 1965
Warner, Charles L.	Feb. 9, 1965
Warner, Howard H.	June 5, 1964
White, William Kelso	Feb. 28, 1965
Smith, Frank R., Jr.	March 31, 1965
Marino, Frank C.	April 17, 1965
Caroline County	
Smith, Horace L.	April 14, 1965
Baltimore County	
Clarke, Sydenham R.	Feb. 26, 1964
Hudson, Rollin C.	May 29, 1964
Loyola, Pablo M.	April 21, 1964
Montgomery County	
Everding, Charles J.	Nov. 30, 1964
Mitchell, Harold B.	June 29, 1964
Rivat, George L.	Sept. 1, 1964
St. Mary's County	
Lane, Julian S.	Oct. 9, 1964
Talbot County	
Cox, P. Evans	March 5, 1965
Seymour, William S.	June 27, 1964
Washington County	
Poole, Ernest F.	Feb. 7, 1965
Warden, Jacob G.	Dec. 22, 1964
Wicomico County	
Bishop, James R.	Dec. 16, 1964
Lederman, Alfred S.	Sept. 21, 1964
Affiliate	
Smith, George W.	April 18, 1964

AUDITOR'S REPORT

The report of the Treasurer for the year 1964 having been distributed, the auditor's report, "that the books and records had been examined and found correct" was adopted.

TREASURER'S REPORT

The Treasurer then reported verbally and presented the 1965 budget for information, it having been adopted by the Council in accordance with the Bylaws. The recommendation for formation of a Finance Committee was referred by the President to the Bylaws Committee for consideration.

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, the following members who had received the recommendation of the Council, were elected to Emeritus membership:

Allegany County:	Emett L. Jones, MD
Baltimore City:	Harry Linden, MD
	John C. Whitehorn, MD
Baltimore County:	William H. F. Warthen, MD
Carroll County:	Thomas F. Vestal, MD
Kent County:	Harry H. Hamilton, MD
Washington County:	Royal A. Bell, MD
	Henry F. Graff, MD

NOMINATING COMMITTEE REPORT

Dr. Boyer, Chairman of the Nominating Committee, on its behalf, presented the following slate of officers:

President-elect
J. Morris Reese, Lutherville (President-elect 1965-66, President 1966-67)

First Vice-President
Everett S. Diggs, Baltimore

Second Vice-President
Henry A. Briele, Salisbury

Third Vice-President
John P. Haberlin, Silver Spring

Secretary
William A. Pillsbury, Timonium

Treasurer
Karl F. Mech, Baltimore

Councilors:
Robert C. Kimberly, Baltimore, Central Dist. (1969)
Henry V. Chase, Frederick, Western Dist. (1969)
Archie Robert Cohen, Clear Spring, West. Dist. (1969)
Manning W. Alden, Annapolis, Southern Dist. (1969)
Merrill M. Cross, Silver Spring, So. Cent. Dist. (1969)

Delegate to American Medical Association
Robert vL. Campbell, Hagerstown (Jan. 1, 1966-Dec. 31, 1968)

Alternate Delegate to American Medical Association
Charles F. O'Donnell, Towson (Jan. 1, 1966-Dec. 31, 1968)

Committee on Program and Arrangements
DeWitt E. DeLawter, Bethesda (1970)
Joseph D. B. King, Baltimore (1965-1969)

Library and History Committee
Louis Krause, Baltimore (1971)
Katharine A. Chapman, Kensington (1965-1967)

Finney Fund Committee
D. C. W. Finney, Baltimore (1971)

Board of Medical Examiners
Wilber R. Ellis, Jr., Salisbury (June 1965-June 1969)
Vernon H. Norwood, Baltimore (June 1965-June 1969)

The floor was opened to further nominations for these offices and there being none, nominations were, by general consent, closed, the election to be held at the second meeting of the session, Friday, April 23, 1965. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 12 Noon, April 22, 1965.

INFORMATION COMMITTEE REPORTS

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions:

Secretary—William A. Pillsbury, MD

Delegates to the American Medical Association—Robert vL. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD

Board of Medical Examiners—Frank K. Morris, MD, Secretary
Executive Secretary—Mr. John Sargeant
Library and History Committee and Finney Fund Committee—Louis Krause, MD and George G. Finney, Sr., MD
Curator—Mason F. Lord, MD
Committee on Program and Arrangements—Richard T. Shackelford, MD
American Medical Association Education and Research Foundation Committee—William S. Stone, MD
†Building Committee—Albert E. Goldstein, MD
†Bylaws Committee—Charles F. O'Donnell, MD
Faculty Representatives to the Congress of Professions—Howard F. Kinnamon, MD
Economics Committee—Paul F. Guerin, MD
Editorial Board, Maryland State Medical Journal—George H. Yeager, MD
Committee on Emotional Health—Jonas R. Rappeport, MD
Fee Schedule Committee—William G. Speed, III, MD
Legislative Committee—B. Martin Middleton, MD
Liaison Committee—John F. Schaefer, MD
†Faculty Representatives on the Maryland Joint Council to Improve the Health Care of the Aged—Albert E. Goldstein, MD
Mediation Committee—John Murray Dennis, MD
Maryland Medical Service, Board of Trustees—J. Sheldon Eastland, MD, President
Medical Annals of Maryland—Leslie E. Daugherty, MD
Medical Emergency Disaster Service Committee—Charles J. Savarese, MD
Medicolegal Committee—Howard F. Kinnamon, MD
Membership Committee—DeWitt E. DeLawter, MD
Occupational Health Committee—John R. Davis, MD
†Policy and Planning Committee—Richard D. Bauer, MD
Committee on Postgraduate Education, Preventive Medicine and Public Health—William L. Stewart, MD
Public Relations Committee—Raymond M. Yow, MD
†Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program

PROFESSIONAL FEE FUND COMMITTEE REPORT

Copies of the Professional Fee Fund Committee report were distributed to the House for its information. On motion of Dr. Cornbrooks, after debate, it was:

Resolved, That the Council distribute a questionnaire requiring each member to return a statement in writing that he either is or is not disposing of his professional attainments or services to any hospital, corporation or lay body, by whatever name called, or however organized, under terms and conditions which permit the sale of services of that physician by such agency for a fee.

RECESS

Thereupon, the House recessed for 10 minutes at 11:25 a.m.

RECONVENED

The House reconvened at 11:35 a.m.

The President, under Article IV, Section 2, appointed Robert vL. Campbell, MD, Speaker of the House for the remainder of the session.

It was pointed out that the room had to be cleared in order to be arranged for the scientific programs scheduled for 2:00 p.m.; and that it had usually been the practice to discuss the Reference Committee report at the second session of the Annual Meeting.

Following this, the first meeting of the Annual Session was, by general consent, adjourned at 11:45 a.m.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, Secretary

† No report. Minutes to be amended September 10, 1965.

ELECTION OF THE BOARD OF MEDICAL EXAMINERS OF MARYLAND

A general meeting of the Medical and Chirurgical Faculty of the State of Maryland was held on Thursday, April 22, 1965 at 12:30 p.m., at the Alcazar, Cathedral and Madison Streets, Baltimore, Maryland, for the purpose of electing two members of the Board of Medical Examiners of Maryland.

The First Vice-President, J. Morris Reese, MD, presided and called the meeting to order.

The names of the two nominees were presented to the General Meeting, as follows:

Wilber R. Ellis, Jr., MD (June 1965-June 1969)
Vernon H. Norwood, MD (June 1965-June 1969)

Nominations from the floor were requested. There being none, the Chairman declared nominations closed.

Election took place by acclamation, and the Secretary, William A. Pillsbury, MD, was instructed to cast one ballot for those nominated.

There being no further business, the meeting adjourned at 12:40 p.m.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, Secretary

MINUTES

The 250th meeting, second of the 167th annual session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland met at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, at 2:10 p.m., April 23, 1965, the Speaker and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors: *A. Andrew Alecce, Baltimore City; *Charles Bagley, Wicomico County; John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Harry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Council; *Henry Briele, Wicomico County; Carlton Brinsfield, Council; Frank E. Brumback, Washington County; Read N. Calvert, Montgomery County; Robert vL. Campbell, Council; Stuart M. Christhilf, Jr., Anne Arundel County; E. Paul Coffay, Jr., Baltimore City; Archie R. Cohen, Washington County; Ernest I. Cornbrooks, Baltimore City; Merrill M. Cross, Montgomery County; Leslie E. Daugherty, Past-President; Louis C. Dobihal, Baltimore City; J. Sheldon Eastland, Council; Robert W. Farr, Council; James McC. Finney, Harford County; Whitmer B. Firor, Past-President; Russell S. Fisher, Council; Seymour Goldgraben, Cecil County; Albert E. Goldstein, Council; Edward G. Grau, Baltimore County; William B. Hagan,

Council; Thurston Harrison, Council; John C. Harvey, Baltimore City; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; William A. Holbrook, Prince George's County; James P. Jarboe, St. Mary's County; James R. Karns, Baltimore City; Fayne A. Kayser, Council; Lauriston L. Keown, Baltimore City; Howard F. Kinnamon, Past President; Louis F. Klimes, Baltimore City; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; *Leon Levitsky, Prince George's County; Charles H. Ligon, Montgomery County; F. Ford Loker, Baltimore City; Charles R. MacDonald, Anne Arundel County; William J. McClafferty, Baltimore City; Hugh B. McNally, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Frank K. Morris, Board of Medical Examiners; *Howard T. Morse, Montgomery County; George A. Moulton, Jr., Carroll County; Joseph E. Muse, Jr., Baltimore City; Charles F. O'Donnell, Past-President; William A. Pillsbury, Council; J. Emmett Queen, Council; Jonas R. Rappeport, Baltimore County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Paul F. Richardson, Baltimore City; Eugene J. Riley, Baltimore City; Donald J. Roop, Council; Edwin Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; William B. Settle, Baltimore City; Aaron C. Sollod, Baltimore City; Omar D. Sprecher, Jr., Washington County; James E. Stoner, Jr., Frederick County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; *William J. Sullivan, Baltimore City; Robert S. Turner, Jr., Frederick County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Hugh W. Ward, Calvert County; Lawrence R. Wharton, Jr., Baltimore City; J. Arthur Weinberg, Council; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Hans Wodak, Prince George's County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; Walter N. Kirkman, Catonsville.

Present also for the meeting were the necessary staff personnel.

The Speaker of the House made several announcements regarding the transaction of business at the meeting and for informational purposes.

BOARD OF MEDICAL EXAMINERS ELECTION

The Speaker advised the House of Delegates of the election of the members of the Board of Medical Examiners at the General Meeting held on April 22, 1965:

Wilber R. Ellis, M.D., Salisbury
(June, 1965-June, 1969)

Vernon H. Norwood, M.D., Baltimore
(June, 1965-June, 1969)

ELECTION OF OFFICERS

There being no further nominations from the floor and there being only one candidate for each of the positions, by unanimous consent the ballot was dispensed with. The following were then elected by voice vote:

President-elect
J. Morris Reese, Lutherville, (President-elect 1965-66; President 1966-67)

First Vice-President
Everett S. Diggs, Baltimore

Second Vice-President
Henry A. Briele, Salisbury

Third Vice-President
John P. Haberlin, Silver Spring

Secretary
William A. Pillsbury, Timonium

Treasurer
Karl F. Mech, Baltimore

Councilors:
Robert C. Kimberly, Baltimore, Central Dist. (1969); Henry V. Chase, Frederick, Western Dist. (1969); Archie Robert Cohen, Clear Spring, West. Dist. (1969); Manning W. Alden, Annapolis, Southern Dist. (1969); Merrill M. Cross, Silver Spring, So. Cent. Dist. (1969)

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Alternate Delegate to American Medical Association
Charles F. O'Donnell, Towson (Jan. 1, 1966- Dec. 31, 1968)

Committee on Program and Arrangements
DeWitt E. DeLawter, Bethesda (1970); Joseph D. B. King, Baltimore (1965-1969)

Library and History Committee
Louis Krause, Baltimore (1971); Katharine A. Chapman, Kensington (1965-1967)

Finney Fund Committee
D. C. W. Finney, Baltimore (1971)

REFERENCE COMMITTEE REPORT

Dr. Ball, on behalf of the Reference Committee, reported to the House with respect to Resolution 1A/65, and recommended that it NOT be adopted.

RESOLUTION 1A/65 NOT ADOPTED

The House rejected Resolution 1A/65, which read as follows:

Whereas, There is progressive accumulating evidence that the advantages of legislation enabling the incorporation of Doctors of Medicine considerably outweigh the disadvantages of such legislation; and

Whereas, State after state, until more than 30, have come to the same conclusion and have adopted such legislation; and

Whereas, The progressive attempts of the various states to provide increasingly safety in this legislation suggest that Maryland could easily study and adopt an acceptable code; therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urges the State Legislature to adopt and approve for this State a modern code enabling the incorporation of physicians and surgeons.

RESOLUTION 2A/65 NOT ADOPTED

Dr. Ball, on behalf of the Reference Committee, recommended that Resolution 2A/65 be NOT adopted.

The House rejected Resolution 2A/65, which reads as follows:

Whereas, Many physicians in private practice wish to become participants in the Social Security program; and

Whereas, At present this is not possible because of the AMA opposition; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland poll its members as to

whether they wish to participate or not to participate in the Social Security System.

RESOLUTION 3A/65 NOT ADOPTED

Dr. Ball, on behalf of the Reference Committee, recommended that Resolution 3A/65, be NOT adopted.

The House rejected Resolution 3A/65, which read as follows:

Whereas, The deleterious effects of cigarette smoking have been documented again and again; and

Whereas, It has been reported in the press that the American Medical Association has accepted a substantial grant from the tobacco industry; and

Whereas, The American Medical Association has refused to go along with the planned labelling of cigarettes as dangerous; therefore, be it

Resolved, That in order to dispel any appearance of bribery, the AMA and its responsible officers be urged to return the grant of the tobacco industry at once.

RESOLUTION REJECTED

On behalf of the Baltimore City Medical Society, Dr. Helfrich moved that the resolution adopted February 20, 1965, imposing a $50 assessment be amended by substituting for it the following resolutions:

Resolved, That a voluntary contribution in the amount of $50.00, in addition to dues, be requested of all active members except those in the first and second years of private practice,

Resolved, That said contribution shall be payable upon adoption of these Resolutions,

Resolved, That members of the Faculty, other than active members to which these Resolutions apply, shall be invited to make a voluntary contribution to the Faculty to be applied to the purposes for which this contribution is intended,

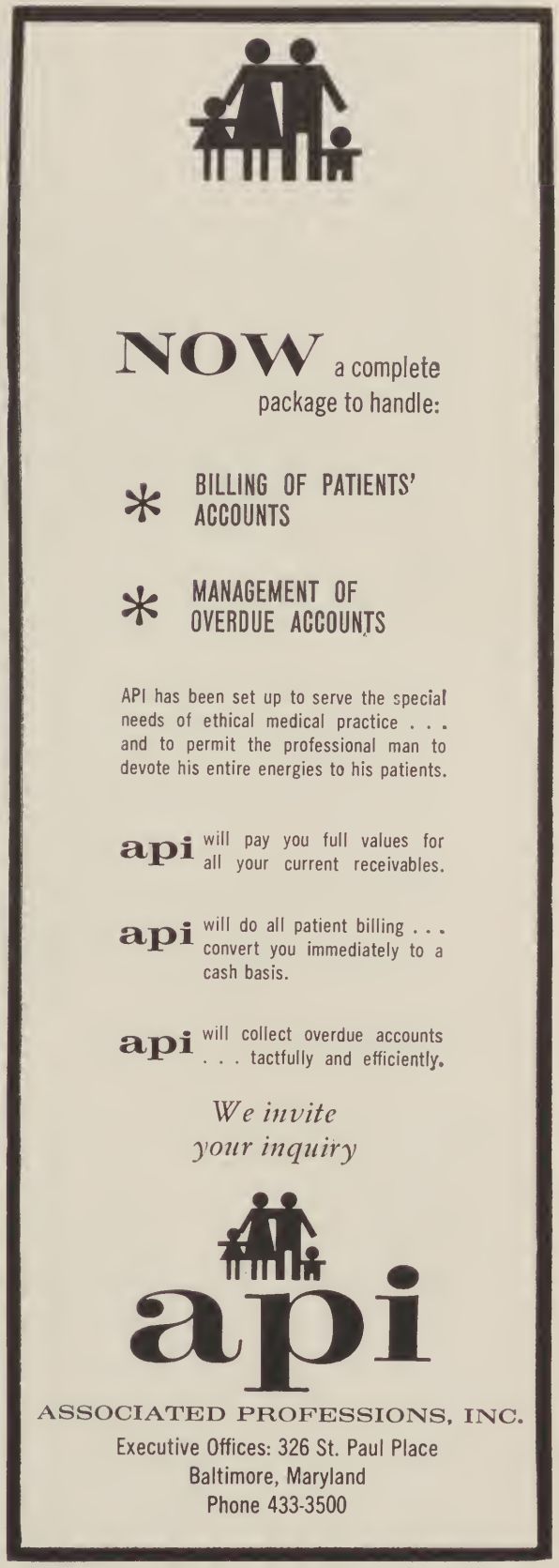
Resolved, That all sums of money raised in this manner be utilized soley for continuing educational purposes related to public and professional education in connection with health care programs, health care for the public, and to continue relating the story of American medicine to the public.

After debate, including non-members of the House of Delegates, the House on a division vote rejected the resolution with 7 in the negative and the balance in the affirmative.

There being no further business, the Speaker turned the meeting over to the President, Albert E. Goldstein, M.D., who assumed the chair and made several announcements.

Dr. Goldstein then introduced to the House the new President, Robert vL. Campbell, M.D., who assumed the chair and by unanimous consent declared the House adjourned *sine die*, at 3:45 p.m.

Respectfully submitted,
WILLIAM A. PILLSBURY, M.D., Secretary



Membership 1964	Membership 1965	Members Paid in advance by Jan. 31, 1965 *Entire County Paid	COUNTIES	New Members	Removed	Resigned	Deceased	U. S. Service	Emeritus	40 Year
72	75	69	Allegany County Medical Society	4		1			2	3
91	108	97	Anne Arundel County Medical Society, Active	6	1				3	
1	2		Anne Arundel County Medical Society, Associate	1						
450	1498	1283	Baltimore City Medical Society, Active	50	47	3	27	22	40	68
359	314	270	Baltimore City Medical Society, Associate	73	34	11				
196	189	174	Baltimore County Medical Association, Active	14		1	2		5	9
9	11	10	Baltimore County Medical Association, Associate	6	4					
6	6	6*	Calvert County Medical Society							
10	10	8	Caroline County Medical Society	1			1			1
40	49	43	Carroll County Medical Society, Active	7					3	1
			Carroll County Medical Society, Associate							
20	21	21*	Cecil County Medical Society, Active		1	1			1	2
7	5	5	Cecil County Medical Society, Associate		2					
10	9	9*	Charles County Medical Society		1				1	
20	23	17	Dorchester County Medical Society						4	
57	59	51	Frederick County Medical Society, Active	4	2				3	4
1	4	4	Frederick County Medical Society, Associate	3						
11	9	8	Garrett County Medical Society		1	1				
42	46	46*	Harford County Medical Society, Active	5		1				
	3	3	Harford County Medical Society, Associate	3						
14	15	15*	Howard County Medical Society	1		1			1	1
15	15	13	Kent County Medical Society						1	
365	399	300	Montgomery County Medical Society, Active	48	3	9	3	1	6	2
34	39	28	Montgomery County Medical Society, Associate	7						
153	164	148	Prince George's County Medical Society, Active	17	1	5			3	
33	33	30	Prince George's County Medical Society, Associate	2						
4	4	4*	Queen Anne's County Medical Society							
17	16	15	St. Mary's County Medical Society, Active				1			
1	2	2*	St. Mary's County Medical Society, Associate							
9	9	9*	Somerset County Medical Society, Active							
1	1	1*	Somerset County Medical Society, Associate							
34	31	31*	Talbot County Medical Society, Active	4			2		1	3
2	2	2*	Talbot County Medical Society, Associate							
84	88	76	Washington County Medical Society, Active	5		1	2		3	7
	1	1	Washington County Medical Society, Associate	1						
67	67	63	Wicomico County Medical Society, Active	4	1		2			
1	2	1	Wicomico County Medical Society, Associate	1						
11	12	12*	Worcester County Medical Society	1						1
163	161	124	Affiliate		3					
2	3		Honorary Members	1						
3412	3505	2999		269	101	35	40	23	77	102

Active Members, 1964.....	2798	Active Members, 1965.....	2922	Gain, Active Members.....	124
Associate Members, 1964...	449	Associate Members, 1965...	419	Lost, Associate Members...	30
Affiliate Members, 1964...	163	Affiliate Members, 1965....	161	Lost, Affiliate Members....	2
Honorary Members, 1964...	2	Honorary Members, 1965...	3	Gain, Honorary.....	1
TOTAL MEMBERSHIP, 1964.....	3412	TOTAL MEMBERSHIP, 1965.....	3505	TOTAL GAIN.....	93

REPORTS

To The House of Delegates

All recommendations and resolutions in **bold type.**

The following committees or designated representatives have no report:

Building Committee
Bylaws Committee
Policy & Planning Committee
Faculty Representative on the Maryland Joint Council to Improve Health Care for the Aged
Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program

SECRETARY

Mr. President and Members of the House of Delegates:

The following component societies have 100% paid-up membership by January 31, 1965: Allegany, Calvert, Cecil, Charles, Harford, Howard, Queen Anne's, Somerset, Talbot, Washington, and Worcester Counties.

At the request of the component societies, the Faculty handled the dues-billing for the following: Allegany, Anne Arundel, Baltimore, Carroll, Cecil, Dorchester, Frederick, Garrett, Kent, Queen Anne's, Washington, Wicomico, and Worcester Counties.

Membership in the American Medical Association dropped slightly from last year. As of December 31, 1963, AMA membership from Maryland was 2,712; as of December 31, 1964, it was 2,551. Our representation of three delegates continues, however.

Blue Cross and Blue Shield enrollment through the Faculty group plan increased from 1,250 in 1963 to 1,298 in 1964.

During the calendar year 1964, 418 meetings were held in the Faculty building by medically oriented groups.

Complete records of all Faculty committees and subcommittees are kept in the Faculty office. These are available for the perusal of Faculty members or chairmen so they may be aware of previous actions in these areas.

Respectfully submitted,
William A. Pillsbury, M.D., Secretary

TREASURER

Mr. President and Members of the House of Delegates:

The 1965 budget and the report on the affairs of the Medical and Chirurgical Faculty for the year of 1964 are presented for your information and as a matter of record in accordance with the Bylaws.

This report marks the completion of my years as treasurer of the Faculty. These years of service to the Executive Committee, the Council, the House of Delegates, and the membership in general have provided a continuing challenge to stabilize and improve the fiscal status of the Faculty and an opportunity to participate actively in the administration of the multitudinous affairs of the office.

Though these years have presented many problems, a perusal of the record will clearly indicate that the Faculty is in a sound financial condition. Rapidly increasing scope and complexity of the administrative affairs indicated the need for a change in our system of accounts. An improved system of records based on accrual accounting and regular reporting of the financial affairs has provided a basis for a more efficient execution of the Faculty's business.

A comprehensive program of salary review and position classification has reflected favorably on the effectiveness of staff operations. A very satisfactory and competitive fringe benefit program is in effect. It must be realized, however, that the institution of this program has increased the cost of Faculty operations.

In previous reports I have stressed the value of our investment program. This program is based upon a continuing Professional Advisory Council provided by the T. Rowe Price group in combination with the Maryland National Bank as custodial administrator. This program has relieved the treasurer and the Executive Committee of the very exacting demands of effectively investing and administering the bequest and trust funds and accounts of the Faculty. I recommend the continuation of this program.

The need for the establishment of a permanent funded reserve has been recognized and made a policy as part of the administration of Faculty funds. Maintenance of an adequate reserve is mandatory to the continuation of sound fiscal policy. This contingency fund has been drawn upon heavily. Your treasurer recommends the prompt complete reimbursement and continuing stabilization of this fund.

Each year the demands on the general funds have made the treasurer's position increasingly difficult. Requests and recommendations by Faculty committees, the governing bodies, and administrative staff have repeatedly exceeded budgetary allowance. Thus it has been mandatory, though a very unpopular position, that regardless of merit and need, unless a recommendation requiring financial support be limited to available budgetary allowance that provision within the same recommendation or resolution arrange for adequate funds. Lacking this very unpopular but quite necessary support, programs, regardless of merit, must be denied or curtailed. Your treasurer has repeatedly found himself embattled upon insisting that a resolution requiring funds must of necessity consider the source of financial support.

The regulations governing the Faculty function properly placed the control of all funds under the control of the treasurer, and this policy is commendable. It is recommended that all Faculty funds be so accounted in accordance with the Bylaws.

The increasing magnitude and complexity of the Faculty's financial affairs has suggested the need for a well planned provision for a Finance Committee to assist the treasurer in the administration of the financial affairs of the Medical and Chirurgical Faculty. I recommend the formation of such a committee and revision of the Bylaws accordingly.

I wish to express my appreciation to the members of the staff for their complete cooperation. One of the most significant improvements in the administration of Faculty affairs has been in the position of office manager and accountant, so effectively administered by Mr. Joseph Harrison. To my able successor, Dr. Karl Mech, I wish success and offer my assistance in any fashion or degree desired. To the members of the Faculty I wish to express my appreciation for the privilege of serving the medical profession of Maryland.

ESTIMATED INCOME
1965

Dues	1964 Actual through November		Budget
B. C. M. S.	$68,277.50	$100,745.00	
Counties	65,912.50	97,675.00	
B. C. D. S.	2,195.00	2,195.00	
		136,385.00	200,615.00
Rental & Services	21,625.00	23,957.00	
B. C. M. S.	4,880.00	5,760.00	
Board of Medical Examiners	385.00	420.00	
Maryland League for Nursing	280.00	—0—	
		27,170.00	30,137.00
Board of Nurses Examiners			
Investment			
General Purpose	2,566.09	3,000.00	
Library Purpose	8,508.56	9,000.00	
		11,074.65	12,000.00
Medical Journal	58,480.82	60,000.00	
Annual Meeting	16,564.70	16,000.00	
Other	10,629.95	5,000.00	
Total	$260,305.12		$323,752.00

ESTIMATED EXPENDITURES
1965

	Budget 1964	Actual through November 1964	Budget 1965	
Auditing	$ 2,000.00	$ 1,003.25	$ 2,000.00	
Legal	3,000.00	2,612.50	4,000.00	
Contributions	300.00	710.00	600.00	A
Fuel	2,000.00	1,201.33	2,000.00	
Gas, electricity, water	4,500.00	4,091.97	4,500.00	
Telephone & telegraph	4,800.00	4,369.01	4,800.00	
Postage	3,700.00	3,570.47	3,700.00	
Household & janitorial	1,500.00	1,709.16	1,500.00	
Property maintenance	2,500.00	3,004.68	2,500.00	
Insurance	1,800.00	1,778.09	2,000.00	
Equipment rental	2,000.00	2,505.31	3,000.00	
New equipment	500.00	213.25	1,000.00	
Office equipment	1,000.00	733.71	1,500.00	
Stationery & supplies	3,000.00	3,021.56	3,000.00	
Salaries	123,511.00	109,712.13	132,702.00	B
Social security	3,500.00	3,008.01	3,700.00	
Unemployment compensation	2,400.00	1,574.01	2,500.00	
Employee's insurance program	1,200.00	1,216.20	3,400.00	
Employee's pension program	10,000.00	9,843.16	10,000.00	
Supplementary hours expense	2,000.00	1,340.80	2,000.00	
Travel	5,000.00	5,762.69	5,000.00	C
Printing—committees	2,500.00	1,642.99	2,500.00	
Printing—governing bodies	1,500.00	1,203.99	1,500.00	
Legislative	7,500.00	9,296.05	5,000.00	D
Library	16,900.00	13,401.25	19,050.00	E
Journal expense	60,000.00	61,720.69	60,000.00	
Annual & semiannual meetings	20,000.00	20,740.30	21,000.00	
Interest to Coggins Fund	5,500.00	5,500.00	5,500.00	
Miscellaneous expenses	3,000.00	2,099.18	6,500.00	F
Total	$297,111.00	$278,585.74	$316,452.00	

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

BALTIMORE, MARYLAND

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31st, 1964

GENERAL FUND

EXHIBIT B

Income		
Dues—Baltimore City Dental Society	$2,195.00	
—Baltimore City Medical Society	68,277.50	
—County Medical Societies	65,957.50	$136,430.00
Rents and Services		
Baltimore City Medical Society	21,625.00	
Others	6,475.00	28,100.00
Meetings—Annual and Semi-Annual—Exhibits		16,564.70
Journal—Advertising	61,695.56	
—Subscriptions	2,316.93	64,012.49
Maryland Hospital Service Fees		1,066.39
Addressograph Service		1,032.85
Interest on Savings Accounts		2,757.87
Miscellaneous		3,772.64
		253,736.94
Transfer from Consolidated Fund—Income for General Purposes—Exhibit F		6,119.18
Total Income		$259,856.12
Expenses		
Accounting Fees		1,003.25
Communications Expense—Postage, Telephone and Telegraph		8,067.69
Contributions		710.00
Equipment Rental		2,595.57
Fuel		1,601.33
Gas, Electricity and Water		4,416.19

Expenses—Continued

Household and Janitorial Services	1,771.21	
Insurance—General	1,939.23	
Hospitalization	1,318.20	
Journal Expense—Printing and Commissions	67,304.20	
Legal Fees	2,863.05	
Legislative Expense	9,465.25	
Printing—Committee	1,682.89	
—Governing Bodies	1,203.99	
Property Maintenance	3,217.16	
Meetings—Annual and Semi-Annual	20,682.03	
Office Supplies	3,062.09	
Purchase of Equipment	1,036.46	
Pension and Major Medical Contribution	10,309.84	
Salaries	120,398.51	
Social Security Tax—Employer's Portion	3,398.88	
Unemployment Insurance—United States	287.47	
—State of Maryland	1,732.03	
Travel	7,226.27	
Supplementary Hours Expense	1,434.65	
Library	4,360.23	
Interest—Coggins Fund	5,500.00	
Miscellaneous	2,480.60	
Total Expenses		291,068.27
Excess of Expenses Over Income—To Exhibit C		31,212.15

STATEMENT OF SURPLUS

For Year Ended December 31st, 1964

GENERAL FUND

		Exhibit C
January 1st, 1964—Balance to Credit of Account		$59,544.25
Addition		
To Increase Air Travel Deposit		25.00
		59,569.25
Deductions		
Excess of Expenses Over Income—For Year Ended December 31st, 1964—Exhibit B	$31,212.15	
Addition to Funded Reserve for Year 1964	498.52	
	31,710.67	
Less—Return of Funded Reserve to Surplus to Partially Offset Deficit of December 31st, 1964	30,552.14	1,158.53
December 31st, 1964—Balance to Credit of Account—To Exhibit A		58,410.72

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31st, 1964

CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT D

Income			
Consolidated Fund Investments			
Bonds			
United States Government and Municipals	$744.80		
Public Utilities, Railroads, etc.	2,441.25	$3,186.05	
Stocks			
Preferred	428.76		
Common	11,939.16	12,367.92	
Interest Special Savings Account—The Savings Bank of Baltimore		266.83	
		15,820.80	
Less—Agency Fees	777.61		
—Broker's Fees	1,055.10	1,832.71	
Net Income—Exhibit F		13,988.09	
Eugene F. Cordell Fund Investments—Exhibit F			
Stocks			
Common	$385.60		
Less—Agency Fee	23.14	362.46	
Gain on Securities Sold—Schedule F-1	4,773.79	5,136.25	$19,124.34
Interest on Savings Account—The Savings Bank of Baltimore—Exhibit F			1,107.85
			20,232.19
Expenses and Transfers—Exhibit F			
Library Purposes—General		7,935.95	
Library Payroll, Maintenance, etc.—General Fund		6,119.18	
Lectureship		776.64	
Cordell Fund		675.00	15,506.77
Excess of Income Over Expenses—To Exhibit E			4,725.42

STATEMENT OF CAPITAL

For Year Ended December 31st, 1964

CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT E

January 1st, 1964—Balance to Credit of Account—Exhibit F	$29,901.38
Addition	
Excess of Income Over Expenses for Year Ended December 31st, 1964—Exhibit D	4,725.42
December 31st, 1964—Balance to Credit of Account—To Exhibits A-1 and F	34,626.80

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES

For Year Ended December 31st, 1964

CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT F

FUND	Distributative Share Per Cent	Balance January 1st, 1964	INCOME RECEIVED DURING YEAR			Balance 1/1/64 Plus Income	EXPENSES				BALANCE DECEMBER 31ST, 1964	
			Interest	Dividends	Direct		Library	Transferred to General Fund * (Exhibit B)	Lectureship	Special	Cash, Investments and Dividends Receivable	Cash on Deposit
Baker	.62	$57.63	$6.82	$86.72		$151.17	$139.35				$11.82	$1.00
Barker, Lewellys F.	.38	34.23	1.99	51.75		87.97	80.52				7.45	1.00
Bowen, Josiah S.	8.51	2,501.02	87.48	1,228.15		3,816.65		$3,662.47			154.18	1.00
Bressler, Frank C.	1.72	500.01	17.40	240.60		758.01		727.00			31.01	1.00
Cordell, Eugene Fauntleroy	3.50	12,594.07	345.00	486.78	$5,136.25	18,563.00				$675.00	17,888.00	8,929.66
Cowles, Nellie N.	.72	704.04	27.23	100.71		831.98	10.80				821.18	808.62
Ellis, Charles M.	4.32	71.99		602.89		674.88		599.68			75.20	
Finney, John M. T.	8.06	4,836.54	188.38	1,123.24		6,148.16	608.84		$274.63		5,264.69	5,124.59
Frick, William F.	14.41	1,190.05	84.75	2,010.09		3,284.89	3,033.18				251.71	1.00
Friedenwald, Julius	.72	216.80	7.43	100.71		324.94					324.94	312.38
Harlan, Herbert	.73	361.54	14.43	102.12		478.09	257.60				220.49	207.75
McCleary, Standish	.72	152.46	5.19	100.71		258.36	34.51				223.85	211.29
Osler Endowment	1.34	404.00	14.09	187.44		605.53					605.53	582.15
Osler Testimonial	7.44	4,232.18	161.37	1,036.52		5,430.07	584.54	200.00			4,645.53	4,516.25
Ruhrah, John	39.14	−1,684.68	.28	5,459.57		3,775.17	3,093.22				681.95	1.00
Stokes, William Royal	2.97	206.60	6.77	414.05		627.42	93.39		291.25		242.78	191.14
Trimble, Isaac Ridgeway	2.53	2,878.86	115.81	353.90		3,348.57			219.76		3,137.81	3,093.67
Woods, Hiram	2.17	644.04	22.53	302.14		968.71		930.03			38.68	1.00
	100.00	29,901.38	1,107.85	13,988.09	5,136.25	50,133.57	7,935.95	*6,119.18	776.64	675.00	34,626.80	23,984.50
			Exhibit E	Exhibit D			Exhibit D				Exhibit E	To Summary

Interest and Dividends—Net	$362.46	
Net Profit on Security Sales—Schedule F-1	4,773.79	
	5,136.25	

Summary—to Exhibit A-1

Cash	$23,984.50	
Dividends Receivable	1,744.67	$25,729.17
Cordell Fund		
Cash	299.09	
Investment	8,598.54	8,897.63
		34,626.80

STATEMENT OF SECURITIES SOLD

For Year Ended December 31st, 1964

CONSOLIDATED FUND—(CORDELL INVESTMENTS)

SCHEDULE F-1

SHARES	DESCRIPTION	SALE PRICE	COST	GAIN OR (—LOSS)
	COMMON STOCKS			
115	Maryland Casualty Company	$7,443.27	$2,813.56	$4,629.71
	FRACTIONAL SHARES			
90/100	Eastman Kodak Company	114.83	—	114.83
50/100	Maryland Casualty Company	29.25	—	29.25
		7,587.35	2,813.56	4,773.79
				To Exhibits D and F

STATEMENT OF CAPITAL

December 31st, 1964

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

EXHIBIT G

FUND	PURPOSE	BALANCE JANUARY 1ST, 1964	NET PROFIT ON SECURITY SALES	BALANCE DECEMBER 31ST, 1964
Baker	Books of Materia Medica	$1,186.27	$8.61	$1,194.88
Barker, Lewellys F.	Library	711.80	5.14	716.94
Bowen, Josiah S.	General	16,693.40	122.01	16,815.41
Bressler, Frank C.	General	3,276.05	23.90	3,299.95
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	6,627.13	48.36	6,675.49
Cowles, Nellie N.	Books on Neurology	1,366.71	10.01	1,376.72
Ellis, Charley M.	General	8,198.57	59.89	8,258.46
Finney, John M. T.	Books, Journals and Lectureships on Surgery	15,281.30	111.59	15,392.89
Frick, William F.	Maintenance—Frick Library, Purchase Books and Journals	27,332.51	199.69	27,532.20
Friedenwald, D. Julius	Maintenance of Friedenwald Room	1,366.72	10.01	1,376.73
Harlan, Herbert	Books on Ophthalmology	1,386.82	10.15	1,396.97
McCleary, Standish	Lectureship and Books on Pathology	1,366.72	10.01	1,376.73
Osler—Endowment	Permanent Endowment for Library by Request of Dr. Osler	2,543.46	18.62	2,562.08
Osler—Testimonial	Medical Books and Maintenance of Osler Hall.	14,101.17	102.97	14,204.14
Ruhrah, John	Library Books, Journals, etc.	74,236.08	542.36	74,778.44
Stokes, William Royal	Lectureships and Books on Bacteriology or Pathology	5,630.57	41.13	5,671.70
Trimble, Isaac Ridgeway	Lectureship Only	4,807.86	35.15	4,843.01
Woods, Hiram	General	4,103.50	30.02	4,133.52
		190,216.64	1,389.62	191,606.26
			Schedule G-1	To Exhibit A-1

STATEMENT OF SECURITIES SOLD
For Year Ended December 31st, 1964
CONSOLIDATED FUND—PRINCIPAL ACCOUNT

SCHEDULE G--

SHARES	DESCRIPTION	SALE PRICE	COST	GAIN OR (—LOSS)
	COMMON STOCKS			
200	United Fruit Corporation	$3,863.09	$5,400.00	—$1,536.91
39	United States Fidelity and Guaranty Company	2,680.17	473.85	2,206.32
	STOCK RIGHTS			
324	American Telephone and Telegraph Company	647.76	—	647.76
165	Pacific Gas and Electric Company	9.25	—	9.25
	FRACTIONAL SHARES			
80/100	General Motors Corporation	63.20	—	63.20
		7,263.47	5,873.85	1,389.62

To Exhibit G

STATEMENT OF CAPITAL
For Year Ended December 31st, 1964
FUNDED RESERVE

EXHIBIT H

INCOME ACCOUNT

January 1st, 1964—Balance to Credit of Account		$2,753.77
Additions		
Dividends	$587.80	
Interest—United States Government Bonds	62.50	
—Savings Account	95.74	746.04
		3,499.81
Deduction		
Agency Fee	39.02	
Transferred to General Fund to Partially Offset Deficit of December 31st, 1964	2,979.45	3,018.47
December 31st, 1964—Balance to Credit of Account—To Exhibit A-2		481.34

PRINCIPAL ACCOUNT

January 1st, 1964—Balance to Credit of Account		9,415.56
Addition		
Cash In Lieu of Shares—Maryland Casualty Company	23.40	
Gain on Sale of 92 Shares Maryland Casualty Company Stock	3,491.72	3,515.12
December 31st, 1964—Balance to Credit of Account—To Exhibit A-2		12,930.68

STATEMENT OF CAPITAL
For Year Ended December 31st, 1964
MEDICAL ANNALS FUND

EXHIBIT I

January 1st, 1964—Balance to Credit of Account	$1,157.84
Addition	
Interest on Savings Account	44.00
	1,201.84
Deduction	
Reimbursement to General Fund for Advances	56.25
December 31st, 1964—Balance to Credit of Account—To Exhibit A	1,145.59

STATEMENT OF CAPITAL
For Year Ended December 31st, 1964
HARVEY G. BECK LECTURESHIP FUND

EXHIBIT J

INCOME ACCOUNT

January 1st, 1964—Balance to Credit of Account		$999.73
Additions		
Dividends	$159.90	
Interest—Savings Account	41.98	201.88
		1,201.61
Deductions		
Agency Fees	9.59	
Reimbursement to General Fund for Advances—(For Lectureship, Honorarium, etc.)	414.00	423.59
December 31st, 1964—Balance to Credit of Account—To Exhibit A-3		778.02

PRINCIPAL ACCOUNT

January 1st, 1964—Balance to Credit of Account	1,997.14
Addition	
Proceeds from Sale of 41 Rights—American Telephone and Telegraph Company	81.96
December 31st, 1964—Balance to Credit of Account—To Exhibit A-3	2,079.10

STATEMENT OF CAPITAL
For Year Ended December 31st, 1964
JESSE C. COGGINS—LECTURESHIP FUND

EXHIBIT K

January 1st, 1964—Balance to Credit of Account	$5,043.55
Addition	
Interest—Savings Account	180.08
	5,223.63
Deduction	
Reimbursement to General Fund for Advances—(For Lectureship)	100.00
December 31st, 1964—Balance to Credit of Account—To Exhibit A	5,123.63

STATEMENT OF CAPITAL
For Year Ended December 31st, 1964
PLANT FUND

EXHIBIT L

January 1st, 1964—Balance to Credit of Account	$683,110.45
Addition	
Assessments	18,650.00
	701,760.45
Deduction	
Interest on Borrowed Money—Maryland National Bank	308.81
December 31st, 1964—Balance to Credit of Account—To Exhibit A	701,451.64

BALANCE SHEET—DECEMBER 31st, 1964

EXHIBIT A

ASSETS

General Fund			
Cash—Maryland National Bank—Checking Account	$20,652.20		
—Maryland National Bank—Savings Account.	2,350.81		
—Petty Cash Funds	454.22	$23,457.23	
—Loyola Federal Savings and Loan Association —Hundley Fund—See Designated—Contra		2,997.41	
—Baltimore Federal Savings and Loan Association—Pension Fund—See Designated—Contra	3,386.97		
Less—Amount Due Checking Account—Maryland National Bank—Below	1,628.04	1,758.93	
—Central Savings Bank		2,613.45	
—Eutaw Savings Bank of Baltimore		12,483.75	
—Provident Savings Bank		12,474.89	$55,785.66
Accounts Receivable			
Dues, Journal Subscriptions, etc.		11,850.33	
Ruhrah Fund		6,625.08	
Pension Fund—Above		1,628.04	20,103.45
Consolidated Fund—Income Account			1.00
Funded Reserve—Contra			2,979.45
Employee			83.75
Loan Receivable—Plant Fund—Contra			34,300.00
Deferred Charges			
Air Travel		425.00	
Annual Meeting		487.26	
Legislative Newsletter "The Assemblyman"		135.00	
Insurance Premiums		1,552.26	2,599.52
Total General Fund Assets			115,852.83
Endowment and Other Special Funds			
Consolidated Fund—Exhibit A-1			
Income Account		34,627.80	
Principal Account		191,606.26	226,234.06

LIABILITIES AND CAPITAL

General Fund			
Liabilities			
Accounts Payable—Trade		$4.738.66	
—American Medical Assn.—Dues Collected		7.550.00	
—Building Fund—Contra		3,204.26	
—County Medical Societies		3,415.00	$18,907.92
Payroll Taxes			
Withholding			
United States—December, 1964		1,329.81	
State of Maryland—Fourth Quarter, 1964		720.95	
Old Age Benefit Tax—December, 1964		360.51	
Unemployment Insurance			
United States—1964		287.47	
State of Maryland—Fourth Quarter, 1964		158.02	2,856.76
Designated Funds			
For—Library Account—Books and Journals		32.54	
—Tetanus Program		287.30	
—The J. Mason Hundley Memorial Fund—On Deposit—Contra		2,997.41	3,317.25
			25,081.93
Reserve for Pension Fund—On Deposit—Contra			1,758.93
Deferred Income—1965 Dues			30,601.25
Surplus—Exhibit C			58,410.72
Total General Fund—Liabilities, Reserves and Capital			115.852.83
Endowment and Other Special Funds			
Consolidated Fund—Exhibit A-1			
Income Account			
Due General Fund—Contra	$1.00		
Capital	34,626.80	34,627.80	
Principal Account			
Capital		191,606.26	226,234.06

Funded Reserve—Exhibit A-2			
Income Account		3,460.79	
Principal Account		13,411.02	16,871.81
Medical Annals Fund			
Cash—Union Trust Company of Maryland			1,145.59
Harvey G. Beck—Lectureship Fund—Exhibit A-3			
Income Account		778.02	
Principal Account		2,079.10	2,857.12
Jesse C. Coggins—Lectureship Fund			
Cash—Maryland National Bank			5,123.63
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account		6,250.00	
Principal Account		102,000.00	108,250.00
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			2,580.53
Total Endowment and Other Special Funds			363,062.74
Plant Fund			
Cash—Maryland National Bank—Checking Account			297.72
Accounts Receivable—General Fund—Contra			3,204.26
Fixed Assets—(No Depreciation Provided)			
1215-1217 Cathedral Street—Land—Cost		19,118.95	
1209-1213 Cathedral Street			
Land and Building—Cost	110,635.76		
Improvements—Cost	331,525.47	442,161.23	
**Personal Property*			
Library Books and Journals	231,370.00		
Office, Library, Fixtures, Antiques and Museum Pieces	77,349.48		
Portraits	65,000.00	373,719.48	834,999.66
			838,501.64
Grand Total—All Funds			1,317,417.21

Funded Reserve—Exhibit A-2			
Income Account			
Account Payable—General Fund—Contra	2,979.45		
Capital	481.34	3,460.79	
Principal Account			
Liabilities	480.34		
Capital	12,930.68	13,411.02	16,871.81
Medical Annals Fund			
Capital—Exhibit I			1,145.59
Harvey G. Beck—Lectureship Fund—Exhibit A-3			
Income Account			
Capital		778.02	
Principal Account			
Capital		2,079.10	2,857.12
Jesse C. Coggins—Lectureship Fund			
Capital—Exhibit K			5,123.63
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account			
Capital		6,250.00	
Principal Account			
Capital		102,000.00	108,250.00
George M. Boyer—Lectureship Fund			
Capital			2,580.53
Total Endowment and Other Special Funds			363,062.74
Plant Fund			
Liabilities			
Jesse C. Coggins—New Building Fund		102,750.00	
General Fund—Contra		34,300.00	137,050.00
Capital—Exhibit L			701,451.64
Total Plant Fund—Liabilities and Capital			838,501.64
Grand Total—All Funds			1,317,417.21

* The appraised value of portraits as of December 31st, 1963 was $65,000.00, an increase of $51,000.00 over prior years. All other Personal Property appraised as of December 31st, 1949, with subsequent additions at cost.

BALANCE SHEET—DECEMBER 31st, 1964

CONSOLIDATED FUND

EXHIBIT A-1

ASSETS

Income Account			
Cash—The Savings Bank of Baltimore—Exhibit F	$23,984.50		
—Special Account—Contra	1.00	$23,985.50	
Dividends Receivable—Held by Maryland National Bank—Exhibit F		1,744.67	
Investments			
Eugene F. Cordell Fund—Held by Maryland National Bank—Agent—Exhibit F			
Cash	299.09		
Common Stock	8,598.54	8,897.63	
Total Income Account Assets—To Exhibit A			$34,627.80
Principal Account			
Held by Maryland National Bank—Agent			
Cash		593.19	
Investments			
United States Government and Municipal Bonds	28,830.00		
Public Utilities and Railroads, etc.—Bonds	60,035.52		
Stocks—Preferred	9,177.92		
—Common	92,969.63	191,013.07	
Total Principal Account Assets—To Exhibit A			191,606.26
Grand Total—Income and Principal Account Assets—To Exhibit A			226,234.06

LIABILITIES AND CAPITAL

Income Account—To Exhibit A	
Liabilities	
Due General Fund	
From Special Savings Account—Contra	1.00
Capital—Exhibits E and F	34,626.80
Total Income Account Liabilities and Capital	34,627.80
Principal Account—To Exhibit A	
Capital—Exhibit G	191,606.26
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A	226,234.06

BALANCE SHEET—DECEMBER 31st, 1964
FUNDED RESERVE

EXHIBIT A-2

ASSETS

Income Account			
Cash—Savings Bank of Baltimore		$2,980.45	
Due from Principal Account—Contra		480.34	
Total Income Account Assets—To Exhibit A			$3,460.79
Principal Account			
Investments—Funded Reserve—Held by Maryland National Bank—Agent			
Cash		178.71	
United States Government Bonds	$2,284.38		
Common Stocks	10,947.93	13,232.31	
Total Principal Account Assets—To Exhibit A			13,411.02
Grand Total—Income and Principal Account Assets—To Exhibit A			16,871.81

LIABILITIES AND CAPITAL

Income Account—To Exhibit A		
Account Payable—General Fund	2,979.45	
Capital—Exhibit H	481.34	3,460.79
Principal Account—To Exhibit A		
Liabilities		
Due Income Account—Contra	480.34	
Capital—Exhibit H	12,930.68	
Total Principal Account Liabilities and Capital—To Exhibit A		13,411.02
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A		16,871.81

BALANCE SHEET—DECEMBER 31st, 1964
HARVEY G. BECK—LECTURESHIP FUND

EXHIBIT A-3

ASSETS

Income Account		
Cash—Savings Bank of Baltimore—To Exhibit A		$778.02
Principal Account		
Investments—Held by Maryland National Bank—Agent		
Cash	$109.36	
Common Stock	1,969.74	
Total Principal Account Assets—To Exhibit A		2,079.10
Grand Total—Income and Principal Account Assets—To Exhibit A		2,857.12

LIABILITIES AND CAPITAL

Income Account—To Exhibit A	
Capital—Exhibit J	778.02
Total Income Account Liabilities and Capital	778.02
Principal Account—To Exhibit A	
Capital—Exhibit J	2,079.10
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A	2,857.12

BALANCE SHEET—DECEMBER 31st, 1964

JESSE C. COGGINS—NEW BUILDING FUND

EXHIBIT A-4

ASSETS

Income Account		
Cash—Loyola Federal Savings and Loan Association	$5,500.00	
Accrued Interest in Principal Account Investments	750.00	
Total Income Account Assets—To Exhibit A		$6,250.00
Principal Account		
Accounts Receivable—Due from Building Fund—To Exhibit A		102,000.00
Grand Total—Income and Principal Account Assets—To Exhibit A		108,250.00

LIABILITIES AND CAPITAL

Income Account	
Capital—To Exhibit A	6,250.00
Total Income Account Liabilities and Capital	6,250.00
Principal Account	
Capital—To Exhibit A	102,000.00
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A	108,250.00

MARCH 23RD, 1965

CERTIFICATE

THE MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND,
1211 CATHEDRAL STREET,
BALTIMORE, MARYLAND. 21201

GENTLEMEN:

We have made an audit of the records in the office of the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31st, 1964. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31st, 1964 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
WOODEN, BENSON & WALTON
Members of American Institute of Certified Public Accountants

EXPLANATORY NOTES ON 1965 PROPOSED BUDGET

The majority of figures are self-explanatory. The budget represents many hours work on the part of the Faculty's Executive Committee.

Budgetary items for 1965 are predicated on the actual cost for 1964. Only items where there is any substantial change will have explanatory notes.

A. Contributions

Student AMA	$250.00
National Society for Medical Research	50.00
Miscellaneous (Maryland League included)	300.00
TOTAL	$600.00

B. Salaries

The increase reflects anticipated salary increments during 1965 and the salary of an additional employee as authorized by Council on September 9, 1964. In addition, 1964 actual figures show salary of one librarian for one-half year only. The 1965 figures also show the salary of an additional library employee for 1965.

C. Travel

Professional Convention Management Association and Medical Exhibitors Association
January 6-9, 1965 One staff member

Annual Congress on Mental Health, Chicago, Illinois
March 5-6, 1965 One staff member

Annual Medicolegal Conference sponsored by the AMA
March 11-13, 1965 One staff member

Medical Society Executives Association (one day) and AMA (five days), New York City
June 1965 One staff member plus four Faculty Delegates

Medical Society Executives Association (one day) and AMA Annual Institute (two days), Chicago, Illinois
August 1965 Two staff members

American Medical Association House of Delegates meeting (four days), Philadelphia, Pa.
December 1965 One staff member plus four Faculty Delegates

Possible special meeting of the AMA House of Delegates (one-two days)
Date not known One staff member plus four Faculty Delegates

State Medical Journal Advertising Bureau Meeting, Chicago, Illinois
October 1965 One staff member

American Medical Writers Association Meeting, Detroit, Mich.
October 1965 One staff member

Any travel for which the Faculty is reimbursed by the AMA or other affiliated, allied, or associated groups is approved without reference to the Executive Committee.

D. Legislative

Operation of Legislative First Aid Room	$1,200.00
Distribution of Legislative Newsletter (5 issues)	1,500.00
Copies of Legislation	200.00
Legislative Representative's Expenses (Travel, meals, telephone, etc.)	500.00
Expenditure for Federal Legislation	1,600.00
TOTAL	$5,000.00

E. Library Expense

Total per Library Budget	$26,695.00
Less: Amount included in salaries A/C	16,640.00
Items not on payroll	10,050.00
Investment income for Library purpose	9,000.00
TOTAL	$19,050.00

F. Miscellaneous Expense

Plaques	$1,200.00
Insurance Consultant	3,000.00
Nutrition Conference	300.00
Other Miscellaneous Expense	2,000.00
TOTAL	$6,500.00

Respectfully submitted,
HOWARD B. MAYS, M.D., Treasurer

COUNCIL

Mr. President and Members of the House of Delegates:

Both the Council and its Executive Committee have met at regular intervals. Business transacted at each meeting has been summarized for the membership in the *Maryland State Medical Journal.*

The Executive Committee has held several joint meetings with the Executive Committee of the Hospital Council. One of the main concerns of the joint group has been implementation and discussion of Gruehn Report recommendations.

Physicians Defense was ratified for 37 members requesting this privilege.

Libel and slander coverage for officers and committeemen has been added to the Faculty's comprehensive liability policy. Amount of coverage is $100,000/$300,000.

The Council approved the hiring of an additional staff member to assist Mr. Chilcoat and Mr. Sargeant. Mrs. Constance Galton was thus employed. Subsequently, Mr. Chilcoat resigned to become a member of the AMA field staff. Reassignment of responsibilities was made so that it is not necessary to replace Mr. Chilcoat at this time.

A teletype machine has been installed linking the Faculty with the AMA and other state medical societies. This was done at AMA expense, the only cost to the Faculty being for messages originated by the Faculty.

Other business transacted included making and approving various appointments, acting on recommendations from Faculty committees, approving special expenditures of funds, and acting on various staff matters.

Emeritus membership is recommended for the following:

Royal A. Bell, MD, Washington County
Henry F. Graff, MD, Washington County
Harry H. Hamilton, MD, Kent County
Emmett L. Jones, MD, Allegany County
Harry Linden, MD, Baltimore City
Thomas Vestal, MD, Carroll County
William W. H. Warthen, MD, Baltimore County
John C. Whitehorn, MD, Baltimore City

Respectfully submitted,
RUSSELL S. FISHER, M.D., chairman

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

CLINICAL SESSION, MIAMI, NOV. 29-DEC. 2

Your three delegates and the senior alternate delegate attended the clinical session of the AMA in Miami, November 29-December 2, 1964.

The chief subject of concern to most of the delegates to this meeting, as well as to the individual members of the AMA, was the question of health care for the aging. The American Medical Association's House of Delegates reaffirmed its position that the medical profession is will-

ing and anxious to work with all governmental agencies to provide health care for those unable to do so through their own resources but remains opposed to any program that would blanket any group in a health program which is established on the basis of age and regardless of need.

The House authorized the Board of Trustees of the AMA to call a special meeting of the House of Delegates if future events necessitate a reconsideration of this policy. In addition, a special conference was scheduled in Chicago to discuss ways and means of informing the public of the positive programs now in existence. Another special conference was scheduled to discuss Kerr-Mills legislation and ways and means to improve such state legislation. By the time this report is printed, both of these meetings, as well as others, probably will have been held.

As is the custom, each of the delegates and the executive secretary attended various Reference Committee hearings to learn the various points of view that are presented on the issues coming before such hearings.

In other actions, the House of Delegates approved a teletypewriter system to link all state society headquarters with the AMA headquarters. This will be done at AMA expense, with state societies being asked to pay for only those messages which it originates and transmits over the leased wires. This is expected to begin operating in July, 1965, and is elective for state societies.

The House also considered the question of arbitrary restrictions by hospitals against general practitioners and other non-specialists. While not adopting the resolution in this regard, the House was assured that the Joint Commission on Accreditation of Hospitals will ascertain, when conducting its inspections, what criteria hospitals use for appointments to its various departments.

Cost of Medical Care

The report of the Commission on the Cost of Medical Care, submitted at the annual session in June, 1964, after study by the Board of Trustees along with its recommendations was submitted for consideration. Several studies were suggested, and some of these are already under way while others are in the process of being implemented.

The House also adopted the following four-point statement on human reproduction:

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

In taking the action, the House also recommended that the AMA cooperate with the appropriate voluntary organizations in the field of human reproduction which have adequate medical direction.

Miscellaneous Actions

In considering a variety of annual reports, special and supplementary reports, and resolutions, the House also:

1. Amended the Bylaws to permit the presidential inauguration to take place at a time other than Tuesday evening and approved a suggestion that the inaugural ceremony at the 1965 annual convention be held on Sunday, June 20;

2) Amended the Bylaws to permit presentation of the AMA Distinguished Service Award at a time to be determined by the Board of Trustees and learned that the Board wishes to present this award at the scientific awards dinner;

3) Agreed that the AMA should cooperate with the U. S. Public Health Service in eradicating the *Aedes aegypti* mosquito from the American hemisphere;

4) Urged strong support of the Woman's Auxiliary and asked the state and county medical societies to give serious consideration to the idea of joint husband-wife membership;

5) Agreed that a section on space medicine should not be created at this time;

6) Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

7) Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the society's annual dues billing statement;

8) Approved a Board recommendation that the 1967 clinical convention be held in Houston, Texas;

9) Agreed with the Board that there should not be an increase in AMA dues at this time;

10) Reaffirmed its approval and support of the National Council for Accreditation of Nursing Homes; and

11) Instructed the Board to re-evaluate the mission of the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported that one out of every six medical students, interns, and residents in the United States is receiving financial assistance from the Foundation's loan fund. The AMA-ERF also announced that Merck Sharp & Dohme pharmaceutical company has made its fourth $100,000 contribution to the loan fund and has pledged an additional $100,000 in 1966. The Faculty presented a check for $9,526.

SPECIAL MEETING, FEB. 6-7, 1965

The Board of Trustees of the American Medical Association called a special meeting of the House of Delegates to discuss the proposed Eldercare program as announced by the AMA early in 1965. More than 200 delegates from the United States and its possessions met in special session all day on February 6 and until noon on February 7.

The House reaffirmed the Board of Trustees recommendations to:

1. Adopt the Association's Eldercare program
2. Reaffirm its concern for all persons regardless of age who need help to meet their health care needs

The House of Delegates did adopt these two recommendations. It was made known that the Board of Trustees had authorized, in accordance with power given it at the December, 1964, clinical session, to commit part of the Association's reserve fund to tell the physicians' story to the public and to Congress. The Board was also authorized to continue studying programs to meet the needs of all persons, regardless of age, who require help to meet their health care expenses and to consider, with appropriate councils and committees, the feasibility of ex-

tending Kerr-Mills Eldercare principles to the needy of all ages.

Seven resolutions were introduced at this meeting, all dealing with the subject under discussion. A full and fair airing of all delegations' opinions, suggestions, and philosophies was given in an open meeting. In the end, full power and authority was granted to the Board of Trustees to proceed in the manner it sees best in dealing with Congress and establishing policies on behalf of America's physicians to implement policies established by the House of Delegates.

Respectfully submitted,
J. Sheldon Eastland, M.D.
Robert vL. Campbell, M.D.
Russell S. Fisher, M.D.

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

Examinations given during the year show the following results:

Applications received for examination			528
Second year students examined	145		
Postponed, withdrawn, or did not appear	52		
Failed to complete	1		
Reexamined after license to meet requirements of other states	1		
Not eligible for license		199	
Examined in second part of examination	114		
Complete examination	163		
Reexamined	52		
Eligible for license		329	528
Passed—American graduates	164		
Passed—Foreign graduates	110		
Failed—American graduates	16		
Failed—Foreign graduates	39	329	
American graduates who failed are as follows:			
Georgetown	1		
Hahnemann	1		
Johns Hopkins	1		
Howard University	8		
Meharry	3		
University of Maryland	2		
Licenses issued after examination	273		
Licenses issued by endorsement of other states' licenses	142		
Licenses issued by endorsement of National Board Certificate	175		
Total licenses issued	590		
Licenses revoked	2		
Licentiates certified to other states	252		
Copies of licenses issued	21		
American graduates examined and reexamined	164		
Foreign graduates examined and reexamined	137		
Foreign graduates approved for examination	50		
Written inquiries from foreign graduates (approximately)	1,200		
Office interviews with foreign graduates (approximately)	150		
Telephone inquiries from foreign graduates (approximately)	600		
Telephone inquiries concerning registration of physicians	1,250		
Written inquiries concerning registration of physicians	2,500		
Registration certificates issued (to 12/31/64)	2,574		

Revocation of Medical License

GRAYSON S. WALDROP, M.D.—The medical license of Grayson S. Waldrop, M.D., was revoked on March 24, 1964, for having committed criminal abortion involving moral turpitude. The case has been appealed.

DOMINICK THOMAS RINALDI, M.D.—The medical license of Dominick Thomas Rinaldi, M.D., was revoked on November 13, 1964, for conspiracy to commit abortion.

EMANUEL M. LEBOWICH, M.D.—The medical license of Emanuel M. Lebowich, M.D., was revoked on November 10, 1964, for the crime of abortion and assault in the second degree to commit abortion.

BENNETT A. ROBIN, M.D.—The license of Bennett A. Robin, M.D., was revoked on February 4, 1965, for making false statements in connection with the submission of results of tests of drugs on a federal form. Dr. Robin has appealed his case.

Hearing

RALPH F. YOUNG, M.D.—Dr. Young was charged with violation of the Federal Food, Drug, and Cosmetic Act. The ruling of the Board is reserved until December 4, 1965, until he has a chance to complete his probation under the sentence of the United States District Court of Maryland and until the Board has the opportunity to observe what efforts Dr. Young will make to improve his practice of medicine.

Special Examination (Oral)

After finding the following physicians eminently qualified for licensure in the State of Maryland, a medical license was issued to the following:

GUNTER K. von NOORDEN, M.D., on April 3, 1964, and JOHN LESLIE ENYART, M.D., on October 16, 1964

Restoration of Maryland License

The medical license of Antonio Ruvolo, M.D., was restored by this Board on May 7, 1964, after receiving documentary evidence of his sanity.

National Board of Medical Examinations

Effective May 7, 1964, the Board endorses the certificates of the National Board of Medical Examinations provided a grade of at least 75% is attained in each subject.

Mexican and Canadian Physicians Practicing in Maryland Without a License in Time of Disaster

This Board is in agreement with the Faculty statement on item 313 in Civil Defense Medical Services to the Budget and Finance Committee Legislative Council, dated October 12, 1964; but the word "license" should be eliminated in permitting Mexican and Canadian physicians to practice medicine in the State of Maryland in time of disaster.

Sixty-first Annual Congress of Medical Education and Licensure

Walter C. Merkel, M.D., Vernon H. Norwood, M.D., Frank K. Morris, M.D., and Joseph D. B. King, M.D., attended the Congress in Chicago, February 6-9, 1965.

Registration of Licensed Physicians

The total number of physicians registered to practice medicine and surgery in Maryland, as of March 26, 1965, is 10,280.

The total number of registered physicians in institutional and private practice in Maryland is 4,871 as of March 18, 1965.

Respectfully submitted,
Walter C. Merkel, M.D., President
Vernon H. Norwood, M.D., Vice President
Frank K. Morris, M.D., Secretary-Treasurer
Karl F. Mech, M.D.
Wilber R. Ellis, M.D.
Wylie M. Faw, Jr., M.D.
Joseph D. B. King, M.D.
John H. Hornbaker, M.D.

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

This April concludes my seventh year with the Medical and Chirurgical Faculty as its executive secretary. During this time, much effort has been devoted to the training of an efficient and hard-working organization. The results of these efforts are now being seen in the dedication and devotion of all members of the Faculty staff.

With the resignation of the assistant executive secretary, work realignments have made it possible to function without a replacement. The spreading of committee and subcommittee staffing has enabled us to serve these groups more efficiently.

It has been and continues to be a pleasure to work with Faculty members who are as enthusiastic about the committee work they do as we are in assisting them do it. The story of our efforts is told in all of the committee reports presented to the House of Delegates.

Respectfully submitted,
John Sargeant

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION COMMITTEE

Mr. President and Members of the House of Delegates:

In 1964, Maryland physicians gave $9,526 to medical education through the AMA-ERF. The check was formally presented at the AMA clinical meeting in Miami Beach by Robert vL. Campbell, MD, Maryland delegate to the AMA and president-elect of the Medical and Chirurgical Faculty.

From the national total collected in 1964, the University of Maryland School of Medicine receives $17,472.45 and the Johns Hopkins University School of Medicine receives $12,736.10. As has been the custom, the checks will be presented to the deans of the respective medical schools at the Presidential Dinner.

Respectfully submitted,
William S. Stone, M.D., Chairman
Albert L. Anderson, M.D.
Richard D. Bauer, M.D.
Norman D. Comeau, M.D.
Newland E. Day, M.D.
Abraham Genecin, M.D.
William B. Gunther, M.D.
Bender B. Kneisley, M.D.
J. Douglass Shepperd, M.D.
Vernon M. Smith, M.D.
Thomas B. Turner, M.D.

FACULTY REPRESENTATIVES TO THE CONGRESS OF PROFESSIONS

Mr. President and Members of the House of Delegates:

This organization has been dissolved, and the money has been prorated to the participating organizations.

Respectfully submitted,
Albert E. Goldstein, M.D.
Howard F. Kinnamon, M.D.

CURATOR

Mr. President and Members of the House of Delegates:

The work of portrait restoration continues, and two more portraits were restored this past year.

We are pleased to acknowledge the following donations to the Faculty's historical collection:

Osleriana and other historical documents, donated by Wetherbee Fort, MD.

Old obstetrical instruments, donated by Maurice E. Shamer, MD.

Phlebotomy set, donated by William J. Supik, MD.

Certificates and diplomas of James Clagett Robertson, MD, donated by his son, Lt. James C. Robertson.

Respectfully submitted,
Mason F. Lord, M.D.

ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

The major activity of this committee has been through its Insurance Subcommittee. Mr. Edward H. Friend, from Washington, D. C., has been employed as actuarial consultant to review the Faculty's insurance programs and make recommendations from the viewpoint of offering Faculty members the best insurance at the least possible cost. April 1, 1965, was set as the target date for his recommendations.

The Health Insurance Review Subcommittee reviewed six cases of fee disagreement between physicians and health insurers.

Medicare Program

Payments through Blue Shield and Blue Cross to physicians and hospitals in Maryland for care rendered to dependents of active duty military personnel totalled $772,511 in 1964. Of this amount, payments for physicians' services amounted to $314,158 and hospital payments were $458,353. These amounts compare with $334,039 and $458,353, respectively, in 1963.

During the year the Medicare Section processed claims for 4,294 physicians' services. Table 1 shows the distribution of these claims by type of care.

TABLE 1
PAYMENTS TO PHYSICIANS

Type of service	Number	Percentage	Amount	Percentage	Average payment per service
TOTAL	4,294	100.0	$314,158.00	100.0	$73.16
Obstetrical	2,331	54.3	222,255.00	70.7	95.35
Surgical	1,101	25.6	59,538.00	19.0	54.08
Medical	862	20.1	32,365.00	10.3	37.56

Since the beginning of the Medicare Program in 1956, maternity care has consistently accounted for the major segment of total care; this pattern was maintained in 1964, with expenditures for obstetrical-type care accounting for 70.7% of the payments for physicians' services. Obviously, the reason for this pattern is the much younger average age of those covered by the program. Surgery accounted for 19%, and medical benefits comprised the remaining 10.3% of payments.

The Advisory Committee for the Medicare Program, a group of physicians appointed by the Medical and

Chirurgical Faculty as a subcommittee of the Economics Committee, continued to be an important factor in the administration of the program and was active throughout the year. The committee acts as an adjudicating body in cases requiring professional judgement and advises the fiscal agent in matters pertaining to professional practice. As in the past, close liaison has been maintained with the office of the Surgeon General of the Army, and in a number of instances the committee's opinion has been sought before rulings or interpretations have been made. During 1964 the committee met bimonthly and acted upon 62 specific cases referred to it at the request of individual physicians or the staff of the Maryland Blue Shield Plan, the fiscal agent. Table 2 shows the distribution of committee cases by type of care.

TABLE 2
DISTRIBUTION OF COMMITTEE CASES BY TYPE OF CARE

Total	62
General Surgery	12
Obstetrics and Gynecology	16
Medical	7
Plastic Surgery	21
Ophthalmology	1
Anesthesia	1
Pediatrics	3
Psychiatry	1

The hospitals of Maryland provided a total of 14,271 days of hospital care to the dependents of servicemen incidental to 2,624 admissions in 1964. The average length of stay per admission was 5.44 days and the average cost per case, $173.53.

During 1964 the Maryland Blue Shield Plan continued to act as fiscal agent for the Faculty in administering the Medicare Program in Maryland. The Plan was reimbursed by the federal government for all expenditures plus a small administrative fee for claims processing.

Respectfully submitted,
Paul F. Guerin, M.D., chairman
William B. Settle, M.D., vice chairman
Arthur Baitch, M.D.
Gilbert L. Banfield, M.D.
Edward M. Barczak, M.D.
Harry J. Connolly, M.D.
Eugene D. Lyon, D.D.S.
Alfred S. Norton, M.D.
Hugh W. Ward, M.D.
Eldridge H. Wolff, M.D.

INSURANCE, SUBCOMMITTEE: Harry J. Connolly, M.D., chairman; William B. Settle, M.D., vice chairman; A. Talbott Brice, M.D., William H. Mosberg, Jr., M.D., Alfred S. Norton, M.D., Edwin M. Ruzicka, M.D., William N. Thomas, M.D., John F. Strahan, M.D.

HEALTH INSURANCE REVIEW SUBCOMMITTEE: William B. Settle, M.D., chairman; Robert G. Chambers, M.D., Charles P. Crimy, M.D., Frank W. Davis, Jr., M.D., Gerald A. Galvin, M.D., Julius M. Waghelstein, M.D.

MEDICARE SUBCOMMITTEE: A. Gibson Packard, M.D., chairman; Wilson Grubb, M.D., Ernest L. Cornbrooks, M.D., Lawrence N. D'Elia, M.D., Barnett Berman, M.D., Harry F. Klinefelter. M.D., E. Ellsworth Cook, Jr., M.D., J. Nelson McKay, M.D., Abraham Kremen, M.D., Robert W. Johnson, 3rd, M.D., Eugene Linberg, M.D.

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

A daylong conference on community mental health was held on September 30, at the Sheraton-Belvedere Hotel. There was an overwhelming turnout of physicians, psychologists, nurses, clergymen, social workers, educators, and mental health association volunteers and staff. The purpose of the conference, which we believe was accomplished, was to bring together laymen and the professions actively engaged in and interested in the care of patients at the community level, thereby becoming better acquainted with each other's responsibilities, ideas, and concepts. The meeting, which included workshops on major mental health issues, was a complete success. The proceedings are being dedicated to John C. Whitehorn, MD, in recognition of his continuing efforts in the mental health field.

The second National Mental Health Conference (AMA) attracted a large group from Maryland, including the chairman of the Faculty committee. The program was excellent.

An educational program concerning mental health has been developed for component medical societies and other interested groups. Speakers are available to talk on topics pertaining to 1) Depression, 2) Modes of Treatment, 3) Psychosomatic Illness, and 4) Children's Problems. Requests for speakers are being received.

The Subcommittee on Religion and Psychiatry has prepared information for clergymen on steps to be taken in securing emergency psychiatric treatment. A request from the Liaison Committee for a list for the clergy to use in making psychiatric referrals has not been acted upon.

The chairman of this committee has been appointed Faculty delegate to the Privileged Communication Study Group established by the Maryland Association of Psychologists. The Faculty has endorsed the concept of privileged communication for the psychiatrist-patient relationship. A meeting was held in December to discuss this matter.

A request was made to the Medicolegal Committee for a symposium on psychiatrist-patient privileged communication. This was declined by the Medicolegal Committee.

The chairman also participated in development of a questionnaire which was sent to all private practicing psychiatrists in Maryland concerning treatment of alcoholics.

In March a staff member of the Faculty and the chairman of this committee attended the eleventh annual conference of state mental health representatives. A splendid program was presented, from which much valuable current information was received.

A tour of the psychiatric facilities at the Prince George's General Hospital is planned for April, 1965. Invitations have been issued to chiefs of medicine and psychiatry and administrators of general hospitals, as well as directors of mental hospitals. A good response has been received.

Respectfully submitted,
Jonas R. Rappeport, M.D., Chairman
William H. Edwards, M.D.
Augusto J. Esquibel, M.D.
Richard H. Pembroke, Jr., M.D.
Kent E. Robinson, M.D.
William J. Peeples, M.D.
Isadore Tuerk, M.D.

FEE SCHEDULE COMMITTEE

Mr. President and Members of the House of Delegates:

Considerable progress has been made in compiling the fee schedule, based on average fees for semi-private pa-

tients. Most of the specialty representatives have presented their respective fee schedules to this committee, and the fees have been accepted pending further review of fees for overlapping specialties. The others are expected to report at the next meeting of this committee.

A special meeting was held with the Surgical Subcommittee to clarify misunderstandings about the fee schedules. The Surgical Subcommittee then agreed to resurvey surgeons' fees; this is to be done every three years.

The Blue Shield Board plans to include coverage for diagnostic radioisotope examinations and requested an appropriate schedule of fees. This was drawn up and released to them.

Respectfully submitted,
William G. Speed, III, M.D., chairman
Katherine H. Borkovich, M.D.
Archie Robert Cohen, M.D.
Charles N. Davidson, M.D.
John R. Davis, M.D.
George H. Greenstein, M.D.
Wilson Grubb, M.D.
Alfred T. Lieberman, M.D.
William V. Lovitt, Jr., M.D.
Howard B. Mays, M.D.
John E. Miller, M.D.
Frank K. Morris, M.D.
Howard A. Naquin, M.D.
Alfred T. Nelson, M.D.
William B. Settle, M.D.
Lex B. Smith, M.D.
Israel Zeligman, M.D.
General Practitioners by Districts:
Leon W. Berube, M.D. (Southern)
Ernest A. Dettbarn, M.D. (Western)
Edward G. Grau, M.D. (Central)
Andrew C. Mitchell, M.D. (Eastern)
Wolcott L. Etienne, M.D. (S. Central)
At Large:
John W. Ashworth, M.D.
John Hornbaker, M.D.
Robert W. Johnson, III, M.D.
Charles E. Loveman, D.D.S.
William H. Mosberg, Jr., M.D.
William L. Stewart, M.D.

SUBCOMMITTEE ON STAFF ACTIVITY: John E. Miller, M.D., chairman Wm. H. Mosberg, Jr., M.D., George H. Greenstein, M.D., Alfred T. Lieberman, M.D.

SURGICAL SUBCOMMITTEE: William B. Settle, M.D., chairman; J. Thompson B. Ambler, M.D., Harold P. Biehl, M.D., John N. Classen, M.D., Jacob C. Handelsman, M.D., Richard V. Hauver, M.D., Elmer Hoffman, M.D., Harry C. Hull, M.D., Deonis M. Lupo, M.D., Daniel J. Pessagno, M.D., Henry G. Reeves, M.D., John O. Robben, M.D., Arthur G. Siwinski, M.D., Douglas H. Stone, M.D.

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

State Legislation

This year the Maryland General Assembly held its first 70-day session. The change in the number of days, however, did not make any difference in the number of bills affecting the health of Maryland's people. While many of such bills were minor amendments to the laws, some could have had sweeping effects on the practice of medicine.

The full details of specific bills and the stand taken by the Faculty, as well as the ultimate disposition of the bills, have already been published in *The Assemblyman.* Five issues of this publication were distributed to all Faculty members and to other interested parties. Appreciation must be expressed to individual members of the Faculty for their assistance in appearing before House or Senate committees to discuss the pros and cons of various bills.

We are happy to report that Senate Bill 170, the Psychiatrist/Patient Privileged Communication bill, was adopted and signed into law by the Governor. This bill had first priority for Faculty action this year.

Federal Legislation

On the federal legislative scene, much activity has taken place in connection with the Eldercare program sponsored by the American Medical Association. We are continuing our efforts to promote a program that will be acceptable to the medical profession.

We would be remiss if we did not express appreciation to all Faculty members who gave so unstintingly of their time in various capacities—filling speaking engagements, conducting letter-writing campaigns, attending meetings to outline strategy, and assisting us in innumerable ways.

Perhaps the most important aspect of our activity on a federal level was that of a meeting with Maryland's congressional delegation. This resulted in the establishment of a liaison committee composed of representatives of all health professions to work with congressmen and senators on legislation in the health fields. Our activity on a national level never ceases; we continue to work in this area all year long.

Respectfully submitted,
B. Martin Middleton, M.D., chairman
John W. Clark, M.D., D.D.S.
I. Rivers Hanson, M.D.
Karl F. Mech, M.D.
Belden R. Reap, M.D.
Jesse Trager, D.D.S.

PRIVILEGED COMMUNICATIONS LEGISLATIVE STUDY SUBCOMMITTEE: E. I. Baumgartner, M.D., Cecil C. H. Cullander, M.D., Worth B. Daniels, Jr., M.D., Matthew Debuskey, M.D., R. Donald Eney, M.D., Augusto J. Esquibel, M.D., Russell S. Fisher, M.D., Virginia Huffer, M.D., John J. Krejci, M.D., J. Elliott Levi, M.D., Ephraim T. Lisansky, M.D., Jonas R. Rappeport, M.D., Edward H. Richardson, Jr., M.D., George Sharpe, M.D., Rennert M. Smelser, M.D., William L. Stewart, M.D.

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

Three new subcommittees have been formed in the past year. A Laboratory Services Subcommittee, whose charge is to consider laboratory services as they relate to the general public health and requirements of the people of Maryland, has developed guides for ethical conduct. This has been referred to the Mediation Committee for further consideration. The problems of blood banking were studied by this subcommittee and principles for their operation were formulated. A third activity of this subcommittee has been the development of proposals for professional education regarding clinical laboratory services.

A Community Hospitals Subcommittee has evolved a plan for several community hospitals to contribute jointly to a medical education program for their house staffs. Funds are now available and a physician is under active consideration for the post of director of medical education.

A Nursing Liaison Subcommittee is attempting to clarify the extent to which nurses may legally perform various medical and paramedical procedures.

The Medico-Religious Subcommittee, whose formation

was reported last year, has held three joint meetings with religious leaders. Mutual problems have been aired and specific programs suggested. A letter has been sent to all hospitals by the Hospital Council urging that considerations be given to providing facilities to the clergy for parking and hanging their coats. The March, 1965, issue of the MARYLAND STATE MEDICAL JOURNAL was devoted to Medicine and Religion and presented papers from the viewpoint of both physicians and clergymen. A film entitled "The One Who Heals" has been ordered and will be available on loan through the Faculty office to component societies and other groups interested.

Under consideration by the Pharmacy Liaison Subcommittee is the development of a code of cooperation. The pharmacy group has under consideration legislation to set ethical standards for operation of pharmacies, but nothing concrete has been done.

Disapproval was expressed of certain comments in the December 3, 1964, issue of the *Blue Shield Physicians' Newsletter,* which were restrictive of the private practice of medicine.

Respectfully submitted,
JOHN F. SCHAEFER, M.D., Chairman
MELVIN N. BORDEN, M.D.
ROBERT E. FARBER, M.D.
PAUL F. GUERIN, M.D.
I. BRADSHAW HIGGINS, M.D.
RALPH G. HILLS, M.D.
WALTER E. JAMES, M.D.
ROBERT E. MAY, M.D.
WM. J. MCCLAFFERTY, M.D.
W. KENNETH MANSFIELD, M.D.
JOHN H. MICHAEL, M.D.
WM. J. PEEPLES, M.D.
THEODORE A. SCHWARTZ, M.D.
VERNON M. SMITH, M.D.
FREDERICK J. VOLLMER, M.D.
H. LEONARD WARRES, M.D.
EDGAR P. WILLIAMSON, II, M.D.

COMMUNITY HOSPITAL PROGRAM SUBCOMMITTEE: W. Kenneth Mansfield, M.D., Chairman, Marvin H. Davis, M.D., Frank A. Faraino, M.D., Mr. Sanford Kotzen, Joseph E. Muse, Jr., M.D., Lawrence M. Serra, M.D., Julius M. Waghelstein, M.D.

LABORATORY SERVICES SUBCOMMITTEE: Frederick J. Vollmer, M.D., Chairman, Wilbur N. Baumann, M.D., Robert L. Cavenaugh, M.D., William B. Culwell, M.D., Paul F. Guerin, M.D., Claude D. Hill, M.D., Howard W. Jones, Jr., M.D., D. Frank Kaltreider, M.D., John K. Frost, M.D., William H. Kammer, Jr., M.D.

MEDICO-RELIGIOUS SUBCOMMITTEE: Edgar P. Williamson, II, M.D., Chairman, Melvin N. Borden, M.D., I. Bradshaw Higgins, M.D., Frederick J. Vollmer, M.D.

NURSING LIAISON SUBCOMMITTEE: John F. Schaefer, M.D., Chairman.

PHARMACY LIAISON SUBCOMMITTEE: John F. Schaefer, M.D., Chairman, Mr. F. S. Ballassone, Melvin N. Borden, M.D., Mr. James P. Cragg, Jr., Mr. Nathan I. Gruz, Mr. Victor H. Morgenroth, Jr., Frederick J. Vollmer, M.D., Edgar P. Williamson, II, M.D.

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

During 1964, a full-time assistant librarian was appointed, Mrs. Gloria Miller, formerly with the Research Institute of Advanced Studies (RIAS) in Ruxton. In addition to the librarian, Mrs. Elizabeth G. Sanford, and Mrs. Miller, the staff consists of one part-time professional librarian, Mrs. Suzanne Essick, and two part-time student assistants as pages.

The greatest change evident to our borrowers is probably the conversion to a card system for charging books and journals. Without extra clerical help, it proved impossible to change the charging system completely in a short period of time. However, the project has progressed steadily, with cards and pockets being typed as the materials circulate. All new books and bound journals are equipped with cards and pockets as processed. The greatest disadvantage, of course, has been the delay occasioned when a patron wishes to charge a large number of books or journals for which cards have not been typed. With temporary help during the summer most of this project could be accomplished.

The Library Page made its return to the JOURNAL late this year and will be a regular feature. It will usually include a selected list of books or other materials of interest acquired during a previous period.

The basement was cleaned in June, and the pages began rearranging journals on the shelves. This job will occupy the pages through 1965 even if additional help is available during the summer.

A big weeding job was also accomplished. Some duplicate titles and an accumulation of items of no value to the library were disposed of. This was a time-consuming chore, as was the shifting of journals which were previously shelved in the stacks without alphabetical arrangement. We now plan to shelve all journals inside the stack room and use the corridor shelves for gift collections that come in from time to time. Shelf space in the library itself has become a problem, necessitating such a plan. The upper stacks are now in order according to type of material (journals, books, transactions) and by classification.

No space has been found for transfer of the rare book collection from the small, crowded room in which it has been housed for several years. Many of the oversize rare books are wrapped and shelved in the stacks because of lack of space here. A room at least 15 feet square is needed for shelving this book collection. A much larger room would be needed if the rare books and other historical and archival materials are to be properly administered and exhibited. Little can be done to improve this situation without adequate, environmentally suitable quarters. The Library and History Committee discussed and presented to the Executive Committee its findings relative to an evaluation of our rare book collection and the need for better housing. No decision has been made on either problem, however.

The major portion of the acquisitions program this year involved bringing the reference collection up to date and setting up an effective ordering system. In the future, we will concentrate more on increasing and updating the subject collections. The vertical file of pamphlets and brochures has been increased; an abstract shelf for concentration of abstracting publications started; and new books are kept in a special location two months before being shelved by subject.

Bibliographies are being prepared as requested on a short-time search basis. Long bibliographies must be executed by the individual patron or arrangements made for a paid overtime assignment.

Institutional membership in the Medical Library Asso-

LIBRARY STATISTICS, 1964

Circulation	
Journals	2,791
Books	1,165
Total	3,956
Attendance	2,022
Courtesy cards issued	5
Bibliographies	151
Additions	
Books added	376
Bound journals added	316
Total	692
Total volumes	91,434
Gifts	
Journals	2,503
Books	142
Pamphlets, reprints, etc.	106
Total	2,751

ciation for this library was reinstated in the spring and individual memberships for all librarians processed. Mrs. Sanford attended the national meetings of both the Medical Library Association and the Special Libraries Association in June.

The library exhibit at the annual meeting featured the first charge-out record used in the Medical and Chirurgical Faculty Library, a selected number of older titles, and a representative collection of new books and journals.

The library received the following monetary memorial gifts: the Charles R. Austrian Memorial Fund, $250 from Mrs. Charles Austrian; memorial, Miss Elizabeth Hunting, $100 from her sister, Miss Alice Hunting; memorials in lieu of flowers, $20 in memory of Dr. Tom Chambers and Dr. Alan Chesney. These funds are in addition to the usual income from the various funds through which our books, journals, and binding are purchased.

Respectfully submitted,
Library and History Committee
Louis Krause, M.D., Chairman
George M. Anderson, D.D.S.
Lester A. Wall, Jr., M.D.
Robert B. Goldstein, M.D.
Paul F. Guerin, M.D.
Finney Fund Committee
George G. Finney, M.D., Chairman
C. Thomas Flotte, M.D.
Richard G. Coblentz, M.D.
Richard W. TeLinde, M.D.
Richard V. Hauver, M.D.

MARYLAND MEDICAL SERVICE BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

Important gains in every phase of its operations in 1964 continued for Maryland Blue Shield an unbroken record of 14 years in which such gains have been recorded. Enrollment growth was the greatest since 1958; more claims were handled than ever before; and all previous records were broken for the amount paid to Maryland physicians for care rendered to Blue Shield subscribers.

During the year 57,992 additional members were enrolled in the various programs, bringing the year-end enrollment total to 841,891, a gain of 7.4%. Of this number, 82.8% are enrolled through organized groups, while the remaining are in the direct-payment category. At the end of the year, total Blue Shield enrollment was 73% of Blue Cross enrollment, compared to 69.5% a year ago.

Group enrollment accounted for 697,009 members as of December 31. Membership under the regular Plan A or Plan B programs accounted for 442,289 of this total; 129,523 were enrolled under the special "Steel" plan, and the remaining 125,197 under the Federal Employees Program.

"Group conversion" membership made up 68.9% of the 144,882 persons in the direct-payment category. The group conversion members are those who were formerly enrolled through groups but who have retained their memberships on a billed-at-home basis after leaving their jobs or retiring; having a higher than average number of older people and retirees, this class of membership consistently experiences high utilization. Another 22.7% consisted of "non-group" enrollees, people whose applications had been accepted after individual medical underwriting. The special program for senior citizens, inaugurated in 1963, doubled in size as a result of the open-enrollment campaign conducted in October, 1964, reaching a total of 9,307 members at year's end. During the year a special program, utilizing Plan B, was developed for college students between the ages of 19 and 24. Despite the fact that it was not available in time to satisfactorily coordinate enrollment efforts with most of the state's colleges, more than 2,900 students had been enrolled in the program by the end of the year. These two special programs accounted for the remaining 8.4% of direct-pay enrollment.

All during the year there was a continuation of the shift from Plan A to Plan B as old members had the opportunity to make the change. Most new enrollees continued to choose the higher level programs; this was particularly in evidence during the special enrollment for Baltimore City employees, in which 97.8% of those enrolling in Blue Shield selected Plan B. As of December 31, almost 60% of Blue Shield members, other than those in the Steel Program, carried the higher level Plan B coverage.

Subscription income during 1964 rose by $1,592,775 (11.8%) over the previous year to a new high of $15,024,649. Incurred claims and operating expenses amounted to $14,947,447, an increase of $2,062,512, or 16%. The resulting $77,202 gain from operations was increased by interest income and other adjustments so that there was a net addition to unallocated reserves in the amount of $264,859.

Blue Shield provided benefits for 319,765 separate services during 1964, an average of 6,150 per week. This compares with a total of 281,023 services covered the previous year. Of this total, 154,791 (49%) were surgical services, about three fifths of which were performed in physicians' offices or hospital outpatient departments. There were 15,245 obstetrical deliveries and caesarean sections covered during the year.

Medical services of various types numbered 38,718, up from 33,222 in 1963. Benefits were provided for 9,575 consultations, two thirds of which were of a multi-system nature. In about 11% of the non-maternity admissions, the Plan covered consultation services.

Benefits were paid to anesthesiologists in 45,880 cases, comprising 59.4% of the surgical and obstetrical admissions. A total of 42,047 radiological services were covered by the Plan during the year, of which about 65% were of a diagnostic nature. The remaining 13,509 covered serv-

ices were for physiatry, electrocardiograms, electroencephalograms, and various kinds of surgical and clinical pathology examinations.

During 1964 the number of physicians participating with Maryland Blue Shield increased by 94, bringing the year-end total to 3,214. This represents about 94% of the actively practicing physicians in the state. Representatives of our Professional Relations Section made 1,782 personal visits to physicians' offices, discussing various aspects of the Plan's operations with physicians and their office assistants.

In April, the Board of Trustees was enlarged by the addition of six public representatives and one physician representative and is now composed of nine physician trustees and seven public representatives. This was a significant forward step which will continue to benefit the Plan in many ways.

My sincere thanks go to all the members of the Blue Shield Board of Trustees, the Medical Relations Committee, and the Reference and Appeals Committee. Their generous contributions of time and sound judgment have provided the Plan with invaluable guidance during the year.

CHARLES N. DAVIDSON, M.D., President

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

The MARYLAND STATE MEDICAL JOURNAL began its fourteenth year with a new cover. The advertising on the cover has been discontinued, and we think the new design is both attractive and more appropriate for a professional journal.

A readership survey was conducted in December. The response was better than we had expected. More than 1,200 questionnaires were returned, and more than 80% rated the quality of the scientific papers as fair or better. A great number of constructive comments were made, and we are attempting to implement many that are feasible.

In October, the MARYLAND STATE MEDICAL JOURNAL was host to the state medical journal regional conference. Judging from the comments made, the program was interesting and helpful.

Special issues have been devoted to health services for the elderly, occupational health, and medicine and religion. A trauma page and a rehabilitation page have been added to the departmental section of the JOURNAL. Sections on maternal welfare and pediatrics are scheduled to start soon.

The financial report for 1964 is as follows:

Cash income received from JOURNAL advertising, subscriptions, and other sources	$64,012.49
Cost of publishing JOURNAL, including salaries, etc., (exclusive of light, heat, office space)	$72,833.76
Expenses over income	$ 8,821.27

The figure shown is not a true deficit, however, as the cost of publishing the transactions of the House of Delegates and the Membership Directory are charged to the JOURNAL. In addition, the JOURNAL office turned over to the library $800 worth of books sent for review.

Respectfully submitted,
GEORGE H. YEAGER, M.D., Editor
DORIS E. FLETCHER, Managing Editor
Editorial Board
JOHN J. CURRY, M.D.
HENRY P. LAUGHLIN, M.D.
LOUIS R. SCHOOLMAN, M.D.
E. T. LISANSKY, M.D.
EDWARD C. H. SCHMIDT, M.D.

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

Among the matters brought before the Mediation Committee were the following:

1. Discrepancy in instances where hospitals do not have educational funds and do not bill for services rendered by interns or residents.—The simplest solution would be that the patient have a claim submitted to Blue Shield and the payment be made to the patient; the physician would bill the patient for services.

2. Professional announcements.—These are ethical as long as they do not carry listings of fees or any other material not in keeping with the dignity of the medical profession. Enclosure of a reply card would be unethical.

3. Charging for cauterization of the cervix.—The practice of the community is to include this service in the cost of a regular office visit except under the most unusual circumstances.

4. Professional billing and collection service.—The services being offered by Associated Professions, Inc., do not appear to be unethical; however, the Mediation Committee neither endorses nor disapproves of such services.

5. Telephone prescriptions.—It is not unethical for a physician to restrict telephoned prescriptions to a selected few pharmacies; patients who wish their prescriptions filled at other pharmacies should have the pharmacist call the physician.

6. Incorrect submission of Blue Shield claim forms.—Faculty policy concurs with Blue Shield regulations that all Blue Shield claim forms should be signed by the physician and certified that he personally rendered the service claimed therein.

7. Disputes between physicians.—Those between physicians of the same component society should originate from the component society. Complaints involving physicians from different component societies would be heard by the Mediation Committee. These should be presented in writing with documentary evidence supporting the charges.

8. Yellow Pages listings.—Physicians listed in Yellow Pages in counties other than their own have been asked to discontinue such listings effective with the next issue of the Yellow Pages.

9. Submission of falsified results of clinical tests.—The physician involved has been reprimanded.

10. Submission of false illness certificate.—The physician involved has been reprimanded and placed on probation for one year.

11. FDA reporting irregular activities.—The FDA has advised that it plans to continue to report convictions of physicians to local state boards for action but not to report any irregular activities to local county or state societies.

12. Completion of Blue Shield claim forms prior to payment of bill.—The Mediation Committee ruled that the physician has the right, as an individual contractor, to request payment of the bill before completing Blue Shield claim forms. In the interest of better patient-physician relations, however, physicians are urged to complete such forms at the request of patients, even though payment is not made.

13. Laboratory Services Subcommittee Report.—This was approved with three small changes.

Mediation Cases Handled During Calendar Year 1964

	Mediation Cases 1964 Total	Cases for Complainant	Cases for Defendant	Cases Pending at 12/31/64	Cases Settled Mutually	No Action	Cases referred to Others BCMS	Referred to Board Medical Examiners	License Revoked	Reprimanded
Allegany County	2			0						
Anne Arundel County	2	1		0						
Baltimore City	46	3	16	6	12	2	7			
Baltimore County	4		3	1						
Calvert County				1						
Caroline County		1	1	0						
Carroll County	0	0	0	0						
Cecil County	0			0						
Charles County	0	0	0	0						
Dorchester County	0	0	0	0						
Frederick County	1		1	1						
Garrett County	0	0	0	0						
Harford County	1	0	1	0						
Howard County	0	0	0	0						
Kent County	0	0	0	0						
Montgomery County	24	14	10	2						
Prince George's County	13	0	9	4						
Queen Anne's County	0	0	0	0						
St. Mary's County			1	1						
Somerset County	2	0	2	0						
Talbot County	0			0						
Washington County	3	1		0						
Wicomico County	0	0		0						
Worcester County	1			1						
CASES HANDLED ON STATE LEVEL		2	2	2				2	1	2

14. Sanitarium ad.—This was ruled illegal because it advertised "treatment of nervous and mental disorders."

A summary of cases considered on both the county and state level is appended.

Respectfully submitted,
John M. Dennis, M.D., Chairman
Leslie E. Daugherty, M.D.
Whitmer B. Firor, M.D.
Howard F. Kinnamon, M.D.
Charles F. O'Donnell, M.D.
M. McKendree Boyer, M.D.
Russell S. Fisher, M.D.
Samuel H. Bryant, D.D.S.
J. Sheldon Eastland, M.D.
Wolcott L. Etienne, M.D.
Louis J. Kolodner, M.D.
Lewis P. Gundry, M.D.
Charles F. Hobelmann, M.D.

MEDICAL ANNALS OF MARYLAND COMMITTEE

Mr. President and Members of the House of Delegates:

The first edition of the *Medical Annals of Maryland* contained the following general headings: an historical section, a biographical section, and a chronological section.

During the 1930's, John Ruhräh, M.D., gathered a lot of information in preparation for the next edition of the *Medical Annals,* covering the period from 1900 to 1925. The historical section and the biographical section have been prepared and are ready for the printer. Nothing has been done toward the chronological section (the portion dealing with significant events in medicine during this period as distinct from the Medical Faculty).

It was apparently Dr. Ruhräh's idea to include in this new volume a historical sketch of all hospitals in Maryland, a historical sketch of the various specialties in existence at the time this second volume was under preparation, a historical sketch of the Baltimore City and State Health Departments, and a historical sketch of the Board of Medical Examiners.

It is also understood that a section was to be devoted to the accomplishments of Maryland medicine in World War I, although no manuscript has been prepared for this particular subject.

A decision must be reached with respect to the contents of Volume II. The volume must be factual and contain no editorial comment. It must be useful, and the material contained therein should be as accurate as it is possible to make it. No undue emphasis should be placed on one specialty or one area over another. A limitation on the number of words for each hospital or specialty should be established, if they are used. Nothing should be included that goes beyond 1925. (Many of the sections dealing with hospitals or specialties embrace periods beyond this date.) It should be decided if we wish to include the section on World War I. If so, who will write it? Do we wish to use the material on the health departments?

Once these and other decisions are reached, we must decide how the second volume is to be published and whether copies should be given to all active members or sold to them. In addition, how should this be financed?

Respectfully submitted,
Leslie E. Daugherty, M.D.

MEDICAL EMERGENCY DISASTER SERVICE COMMITTEE

Mr. President and Members of the House of Delegates:

The committee chairman attended a seminar on "The Physician's Role in Disaster Medicine, which was held at the National Naval Medical Center in October, 1964, and sponsored by Med-Chi, Maryland Public Health Department, and National Naval Medical Center. This seminar was considered most informative and worthwhile.

William J. Peeples, M.D., the new health commissioner for Maryland was welcomed as a member of the MEDS Committee, replacing Dr. Prather.

The committee chairman testified at a hearing before the joint House-Senate Subcommittee as it began hearings on the Civil Defense Agency's budget. Another group testified in an attempt to abolish the civil defense program in Maryland. After this testimony, a letter was sent to all members of the Joint Subcommittee and to members of the House Ways and Means Committee, House and Senate Civil Defense Committees, and Senate Finance Committee, reaffirming the MEDS Committee's support of the principles of civil defense. Several replies have been received from the congressmen.

The Maryland Ambulance and Rescue Squad Association, through the Subcommittee on Emergency Medical Care of the State Health Department (Russell Fisher, M.D., chairman), is in the process of preparing a training manual.

A natural disaster plan has been developed for Baltimore City. This program is under the direct leadership of the Baltimore City Health Department with cooperation by Baltimore City Hospitals, Johns Hopkins Hospital, Sinai Hospital, and University Hospital. In the event of a natural disaster in Baltimore City, the hospital farthest from the scene of the disaster will supply an emergency medical team comprising six doctors and four nurses to be transported to the disaster site.

The Subcommittee on Physicians Assignments has encountered difficulty in securing the cooperation of the hospitals in setting up teams to man the 200-bed emergency hospitals. The hospitals are unwilling to take the initiative in setting up an emergency organization. This subcommittee then attempted to get lists of names of physicians from each hospital who are not on priority assignment to the hospital, these to be used by the subcommittee in making assignments. This information has not been forthcoming, and we are exploring new ways of approaching the problem.

Respectfully submitted,
*Charles J. Savarese, M.D., chairman
*Frank E. Brumback, M.D.
*E. Roderick Shipley, M.D.
*I. Ridgeway Trimble, M.D.
*Philip Whittlesey, M.D.
*R. Lane Wroth, M.D.
Raymond M. Cunningham, M.D.
Kirk Moore, M.D.
William J. Peeples, M.D.
Robert J. Wilder, M.D.

SUBCOMMITTEE ON PHYSICIAN ASSIGNMENTS: Raymond M. Cunningham, M.D., chairman; Philip Whittlesey, M.D., E. Roderick Shipley, M.D., Mr. Herbert Bateman, Mr. Joseph Mikos, Mrs. May Foreman, Mr. Rudolf Pendall, Gen. Kenneth Sweany (Ret), Mr. Kimmett Topfer, Mr. Aaron Friedenwald, Mr. Martin C. McMahon, C. Gottfried Baumann, M.D.

* Coordinating Council

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Medicolegal Committee, in addition to preparing the Medicolegal Code of Cooperation adopted at the Semiannual Meeting, has sponsored two symposia during the last year. The first, held on May 20, 1964, was on "Power of the States to Impose Medical Treatment (Transfusions, Immunizations, and General Medical Care)"; the second on "Autopsies," was held at the Court House on October 30. A third symposium is being held in conjunction with the Faculty's 1965 Annual Meeting on April 21. The subject is "The Changing Pattern of Medicolegal Action."

The committee has only held three meetings during the year, most of the work being done in subcommittees. There were 12 subcommittee meetings. Subcommittee appointments were made in cooperation with the chairman of the Legal Section, Theodore E. Waters, Esq.

This past year it has been the responsibility of the medical section to select one of its members as overall chairman. It has been my pleasure to serve in this capacity.

During the coming year, the Medicolegal Committee hopes to sponsor a symposium for the benefit of medical students, interns, and residents at both medical schools

and university hospitals. If successful, it is hoped that this can be done on a continuing basis.

Respectfully submitted,
Howard F. Kinnamon, M.D., Chairman
Conrad Acton, M.D.
James G. Arnold, Jr., M.D.
Everett S. Diggs, M.D.
E. W. Ditto, Jr., M.D.
Russell S. Fisher, M.D.
William E. Grose, M.D.
Robert W. Johnson, III, M.D.
J. Elliot Levi, M.D.
F. Ford Loker, M.D.
Belden R. Reap, M.D.
Edwin Ruzicka, M.D.
William G. Speed, III, M.D.

SUBCOMMITTEE ON SYMPOSIA MANAGEMENT: Sol C. Berenholtz, Esq., chairman; Howard F. Kinnamon, M.D., Theodore E. Waters, Sr., Esq., James G. Arnold, Jr., M.D., Everett S. Diggs, M.D., L. Whiting Farinholt, Jr., Esq., William E. Grose, M.D., J. Elliot Levi, M.D., Charles E. Orth, Jr., Esq., Edwin Ruzicka, M.D.

SUBCOMMITTEE ON GUIDELINES FOR OPERATION AND ORGANIZATION OF THE MEDICO-LEGAL COMMITTEE: Howard F. Kinnamon. M.D., Conrad Acton, M.D., J. Elliot Levi, M.D., William G. Speed, III, M.D., Sol C. Berenholtz, Esq., L. Whiting Farinholt, Esq., Charles E. Orth, Jr., Esq.

MEMBERSHIP COMMITTEE

Mr. President and Members of the House of Delegates:

Past president's certificates have been prepared and will be awarded to all living past presidents of the Faculty during this annual meeting.

A number of membership certificates have already been distributed. Those for members of the Prince George's, Montgomery, and Wicomico County societies are available through the component society office. The remainder may be picked up from the Faculty office.

Two membership booklets have been published. One is distributed by the Board of Medical Examiners to all new licensees; the other is available for distribution through components.

The AMA has made affiliate membership available to certain categories of people in allied professions. These people are also eligible for associate membership in the Faculty, and we are making contact with such groups.

Respectfully submitted,
DeWitt E. DeLawter, M.D., chairman
Edward A. Flanigan, Jr., M.D.
Frank T. Kasik, Jr., M.D.
Nathan E. Needle, M.D.
Emmanuel Schimunek, M.D.
Hugh W. Ward, M.D.
Alan C. Woods, Jr., M.D.

OCCUPATIONAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

This committee provided articles for an Occupational Health issue of the Maryland State Medical Journal in September, 1964. This was well received.

At the November, 1964 meeting, Faculty's legal counsel clarified the relationship of a patient to an occupational health physician; namely, a patient-physician relationship does exist, and the physician should inform the patient of any adverse findings.

Respectfully submitted,
John R. Davis, M.D., chairman
William F. Cox, III, M.D.
Walter E. Fleischer, M.D.
Herman J. Halperin, M.D.
Harry L. Knipp, M.D.
Patrick C. Phelan, Jr., M.D.
Donald J. Roop, M.D.
L. W. Saunders, M.D.
S. Jack Sugar, M.D.

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

Development of a program of postgraduate education for physicians throughout the state, especially those at some distance from Baltimore City, has been one of the concerns of the committee this year. Frederick Memorial Hospital has devised a successful postgraduate program. Dr. Richard Reynolds was present at one of our meetings to describe it and answer questions. The State Health Department has appointed Frederick J. Heldrich, Jr., M.D., to develop a statewide program of continuing education. We have invited Dr. Heldrich to become a member of this committee.

A nutrition seminar, held at the Sheraton-Belvedere Hotel in conjunction with the Dairy Council of the Upper Chesapeake Bay, was a complete success. The morning session, featuring three prominent speakers, was attended by a capacity audience, and all the workshops in the afternoon had reservations almost double the number anticipated. The guest speaker at the luncheon was Frederic J. Stare, MD, of the Harvard School of Public Health. Invited to these sessions were physicians, nutritionists, nurses, and other paramedical groups. We believe this nutrition seminar was a valuable educational undertaking.

The committee is updating a roster of scientific speakers and their subjects for use by component medical societies. The last such roster was compiled in the early 1950's.

A large portion of this committee's work is done by the subcommittees.

Aging

The Subcommittee on Aging has been developing a retirement counseling handbook for the public. It has also worked closely with the State and City Health Departments toward improving the medical care programs. A perforated insert giving information on Maryland's medical care programs was included in the December issue of the Maryland State Medical Journal.

The May issue of the Maryland State Medical Journal featured papers presented at the conference on Health Services for the Elderly.

Alcoholism

The Subcommittee on Alcoholism has been especially active. It sponsored a seminar for physicians on treatment of alcoholics, which was exceptionally well attended and well received. Another seminar is being planned, this one to explore the problems of admitting alcoholics to general hospitals.

A lecture program has been developed on the treatment of alcoholism. This is available to medical staffs of general hospitals and to component medical societies. The first lecture and film was presented at a meeting of the Four County Medical Society, on the Eastern Shore, and elicited a great deal of interest.

Exhibits on alcoholism were shown at the 1964 annual meeting of the Medical and Chirurgical Faculty, the May,



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references: 1. Winfield, I. W.: Am. J. Gastroent., 31:438, 1959. 2. Blanchard, K.: Rocky Mt. Med. J., 54:527, 1957.



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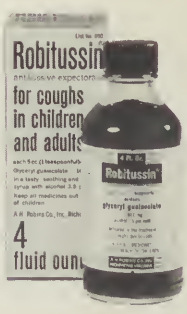
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*Boyd, E.M., and Ronan, A.K.: Am. J. Physiol., 135:383, 1942.

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1964, meeting of the Maryland Academy of General Practice, and the seminar for treatment of alcoholics.

A questionnaire has been devised and sent to private practicing psychiatrists to determine the extent and methods of treatment of alcoholics by this group of specialists. The responses are now being analyzed; however, the impression is that few psychiatrists treat alcoholics.

The Alcoholism Clinic in the Eastern Health District has had a larger response than anticipated. The Board of Estimates in Baltimore City approved an increase in operating funds to permit employment of two more social workers. The Subcommittee on Alcoholism and the Baltimore City Health Department are supporting a request for a roving diagnostic team to help the courts evaluate and treat alcoholics. Such a team would also complement the work of the Alcoholism Clinic.

The subcommittee endorsed the appointment of a full time coordinator of alcoholic services under the Baltimore City Health Department. Father Harry E. Shelley has been appointed to this post and is an ex officio member of this subcommittee.

Child Welfare

The Child Welfare Subcommittee has been primarily concerned with PKU testing and the Battered Child Law. The state legislature is attempting to make PKU testing compulsory and may introduce such a bill at the next session. The Battered Child Law now requires doctors to report such cases, but the law may be changed to include follow-up on the cases reported.

Diabetes

The Subcommittee on Diabetes again conducted a diabetes detection drive in November. Participating in the program were Baltimore City and Baltimore, Frederick, Washington, and Wicomico Counties. In Baltimore, more than 4,200 people were screened, and 45 diabetics were reported who gave no previous history of diabetes. Other testing programs included one at the Harlem Park Health Fair and one at the Clifford T. Perkins Home.

Camp Med-Chi had 103 diabetic children last summer and had to turn some away. A benefactor has given 45 acres of ground to Camp Med-Chi and is raising funds to construct new buildings.

Maternal Welfare

The Maternal Welfare Subcommittee has continued to review cases of maternal deaths. These have reached an all-time low. Arrangements have been made with the Maryland State Medical Journal to publish each month some of the more interesting cases, with identifying features disguised. This series is scheduled to begin with the May issue.

Pelvic Cancer

In July, 1964, the Subcommittee for the Study of Pelvic Cancer ended the study that had been carried on since 1952. This study had reviewed, from the standpoint of delay in diagnosis or treatment, a total of 3,043 cases of pelvic carcinoma which were under treatment in the hospitals of Baltimore City which were cooperating in the review. During the years of the study there has been a significant decrease in the period of delay before patients come to treatment.

The Subcommittee is now undertaking a study to determine the incidence and treatment results in carcinoma of the cervix on a statewide basis. Meetings have been held with chiefs of gynecological-obstetrical service from hospitals throughout the state and the study approved.

Tetanus Immunization

Program materials on tetanus immunization have been distributed to the component societies, and posters outlining correct immunization procedure have been distributed to industrial concerns throughout the state. Several counties have already conducted extensive tetanus immunization programs.

Traffic Safety

The Traffic Safety Subcommittee opposed a program of physical examination of drivers, as it would be too cumbersome. Many abnormalities would be obvious if applicants had to reapply in person for their license; the subcommittee favors this proposal.

This subcommittee recommends adding to the drivers application form a question similar to the following: "Have you in the past five years been treated for a heart attack, blackouts, mental illness, paralysis, etc."

Under consideration in the subcommittee is a program similar to that in Nova Scotia for detecting unstable drivers.

Tuberculosis

The Subcommittee on Tuberculosis has nothing specific to report, as it is currently on a standby basis.

Respectfully submitted,

William L. Stewart, M.D., chairman
Ruth Workman Baldwin, M.D.
Edward M. Barczak, M.D.
Robert E. Farber, M.D.
Norman R. Freeman, Jr., M.D.
Karl M. Green, M.D.
Frederick J. Heldrich, Jr., M.D.
John H. Hirschfeld, M.D.
William P. Horton, M.D.
C. Rodney Layton, M.D.
Robert E. Martin, M.D.
William J. Peeples, M.D.
H. Melvin Radman, M.D.
Ramsay B. Thomas, M.D.
John Whitridge, Jr., M.D.

SUBCOMMITTEE ON AGING: C. Rodney Layton, M.D., chairman; Archie R. Cohen, M.D., W. Grafton Hersperger, M.D., Louis Krause, M.D., Mason F. Lord, M.D., Herman Seidel, M.D., Hugh W. Ward, M.D., Page C. Jett, M.D.

SUBCOMMITTEE ON ALCOHOLISM: John H. Hirschfeld, M.D., chairman; Conrad Acton, M.D., Newland E. Day, M.D., Lewis P. Gundry, M.D., Irene Hitchman, M.D., Frank L. Iber, M.D., Isadore Kaplan, M.D., Kenneth Krulevitz, M.D., Abraham Schneidmuhl, M.D.

CHILD WELFARE SUBCOMMITTEE: Karl F. Green, M.D., chairman.

SUBCOMMITTEE ON DIABETES: Abraham A. Silver, M.D., chairman; Robert E. Ensor, M.D., Sidney J. Venable, M.D., Kay Edwards, M.D., Seth H. Hurdle, M.D., Henry J. Jouska, M.D., W. Grafton Hersperger, M.D.

MATERNAL WELFARE SUBCOMMITTEE: John Whitridge, Jr., M.D., chairman, J. Morris Reese, M.D., George H. Davis, M.D.

SUBCOMMITTEE FOR THE STUDY OF PELVIC CANCER: Howard W. Jones, Jr., M.D., chairman; Silvio A. Alessi, M.D., Everett S. Diggs, M.D., John C. Dumler, M.D., Gerald A. Galvin, M.D., Claude D. Hill, M.D., Theodore Kardash, M.D., Nicholas J. Kohlerman, M.D., Conrad Julian, M.D., Charles B. Marek, M.D., Frank K. Morris, M.D., Richard Munford, M.D., Edward H. Richardson, Jr., M.D., Isadore A. Siegel, M.D., A. Adler Sondheimer, M.D., Umberto VillaSanta, M.D.

SUBCOMMITTEE CONSIDERING PROGRAMS OF TETANUS IMMUNIZATION AND THE USE OF STANDARD HEALTH RECORDS FORMS THROUGHOUT THE STATE: Robert E. Martin, M.D., chairman; William A. Andersen, M.D., Raymond M. Atkins, M.D., George T. Gilmore, M.D., Leroy W. Saunders, M.D.

TRAFFIC SAFETY SUBCOMMITTEE: Ruth Workman Baldwin, M.D., chairman; George O. Eaton, M.D., D. C. W. Finney, M.D., Wm. H. M. Finney, M.D., Irene Hitchman, M.D., William P Horton,

M.D., Howard F. Kinnamon, M.D., Paul H. Royse, M.D., Mr. Earl Smith.
TUBERCULOSIS SUBCOMMITTEE: Robert E. Farber, M.D., chairman.

PROFESSIONAL FEE FUND COMMITTEE

Mr. President and Members of the House of Delegates:

On September 11, at the Ocean City Meeting, the House of Delegates adopted the recommendations of your Professional Fee Fund Committee that "all physicians in Maryland who are members of the Faculty be advised that in regard to the corporate practice of medicine, they must comply with the Principles of Medical Ethics as established by the American Medical Association, and that failing to do so will result in charges being brought against them for unethical conduct through the mechanisms provided in the Faculty Bylaws and the Medical Practice Act of Maryland," and further that, "Immediate steps should be taken to ascertain the legality of corporate practice in Maryland, by court action if necessary."

Our committee was asked to proceed with implementation of the recommendations. Of course, the "implementation of the recommendations" being the privilege only of elected officers of the Faculty, the committee could act only in an advisory capacity; but we met on November 6, 1964, with representatives of the Board of Medical Examiners, and the chairman of the Faculty's Mediation Committee to draft a letter and questionnaire to be sent to all members.

The letter which all of you received on April 9th was not exactly what your Committee proposed, and there is great doubt in our minds that it will accomplish the objective intended. We feel that *each* of our physicians members should state *in writing* that either he *is* or he *is not* "disposing of his professional attainments or services to hospital, corporation, lay body by whatever name called or however organized under terms or conditions which permit the sale of services of that physician by such agency for a fee."

This is the language of the AMA Principles of Medical Ethics, which as outlined in the Faculty's Bylaws, Article XIII, "govern the conduct of members in their relations to each other and the public," and your committee feels we must willingly obey these principles as we have agreed or relinquish our membership in the organization if we find its Code of Ethics too burdensome.

It seems likely that all who are practicing ethically would be willing to say so at once, and the situations of others could then be adjusted promptly. **We therefore recommend the House of Delegates herewith approve the distribution by the Council of such a questionnaire, requiring the return of the statement suggested above.**

Respectfully submitted,
William B. Settle, M.D., Chairman
Harry J. Connolly, M.D.
George O. Eaton, M.D.
Theodore Kardash, M.D.
William H. Mosberg, M.D.
Harry M. Robinson, Jr., M.D.
John F. Schaefer, M.D.
Richard W. TeLinde, M.D.

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The 166th Annual Meeting of the Medical and Chirurgical Faculty, held in May 1964, had a larger registration than any previous meeting. The total registration was 1,424, of which 861 were physicians and the remainder included residents, medical students, guests, and exhibitors. The round table luncheon and presidential dinner both proved most popular with a capacity attendance.

One hundred and eighty-three persons registered (practically all physicians) for the health evaluation tests, which were given for the first time at a Medical and Chirurgical Faculty meeting. These tests included EKG's, chest x-rays, blood analyses, and other laboratory tests. Many significant, previously unknown abnormalities were found.

All technical exhibit space was sold, and the exhibitors were quite satisfied with the meeting in general and particularly with the interest shown by the attending physicians.

This successful meeting was conducted under the chairmanship of Joseph B. Workman, MD, with Charles S. Petty, MD, chairing the Subcommittee on Health Evaluation Tests and Vernon M. Smith, MD, the Subcommittee on Exhibits.

The Semiannual Meeting was again held at the Commander Hotel, Ocean City, with a high registration of 385. Colonel William D. Tigertt, director and commandant, Walter Reed Army Institute of Research, discussed "Medical Problems in Southeast Asia" before a most enthusiastic audience. The Maryland Chapter of the American College of Surgeons, the Heart Association of Maryland, the Maryland Diabetes Association, the Maryland Society of Pathologists, and the Maryland-District of Columbia Society of Anesthesiologists held meetings in Ocean City in conjunction with the Faculty meeting.

The current Committee on Program and Arrangements has planned for the 1965 Annual Meeting a postgraduate program of outstanding lectures and lecturers, presenting much new and valuable scientific information. The always popular round table luncheon will again be held, and the annual presidential dinner will feature entertainment by prominent humorous and musical artists. There will be scientific exhibits of new and varied interest.

Health evaluation tests will again be available for the members of the Faculty. W. Bradley King, Jr., MD, is chairman of the present subcommittee for the tests.

Fifty-five technical exhibits by pharmaceutical companies, book publishers, and others will be displayed. All booths have been sold, and there is a waiting list of prospective exhibitors. Due to expenses, the charge for exhibit space was increased slightly. The income this year will be approximately a thousand dollars more than in 1964. The chairman of the Subcommittee on Exhibits is John Collins Harvey, MD.

As a result of the action of the House of Delegates last year, funds have been appropriated from the dues income of the Society, which enable us to maintain the high quality and enlarge the scope of the medical meetings.

Respectfully submitted,
Richard T. Shackelford, M.D., Chairman

JOHN COLLINS HARVEY, M.D.
JAMES B. BROOKS, M.D.
THADDEUS E. PROUT, M.D.
CALVIN J. GAVER, D.D.S.
SUBCOMMITTEE ON EXHIBITS: John Collins Harvey, M.D., chairman; James B. Brook, M.D., Michael I. O'Connor, J. F. Waldrum, Jr.

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

The Public Relations Committee has had a fruitful year. Meeting frequently with several special meetings and one joint meeting with the Legislative Committee, we look back on the year with a feeling of satisfaction.

The major items which have been of interest to our committee this year are enumerated and discussed.

Medical Practice Act

Several instances of lack of understanding of the Medical Practice Act of Maryland have come to our attention. It was felt that this law needed clarification and to be called to the attention of the membership. An article was planned for the MARYLAND STATE MEDICAL JOURNAL in the form of a statement from the Board of Medical Examiners and the PR Committee. It was brought to our attention, however, that the law was undergoing certain revisions of wording, and the committee decided to await the outcome of this before proceeding on this matter.

Community Health Week

We observed the second annual Community Health Week in October. Efforts were made to encourage all component societies to actively participate. Many did, but unfortunately some of the county societies did not. Outstanding was the poster contest conducted by the Wicomico County Medical Society. This contest allowed the participation of some 350 school children who made posters on health topics. The success of the program drew the attention of the AMA and resulted in a feature story in the Jan-Feb *PR Doctor*. The community health observance is an excellent vehicle for county society activity, and continued efforts in this area is recommended.

Speakers Bureau Training Program

With the gracious and capable help of the Smith, Kline and French Speakers Training program, two training sessions of two days each were held during the year. We are grateful to Dr. Haakenson and his staff for their unstinting help. The March, 1965, session included members of the dental profession as well as physicians. We plan to conduct at least two such sessions each year. Participants will be asked to indicate a willingness to join the Speakers Bureau of their component society and to be available to the Faculty should the need arise.

Public Relations Conference

The first annual Public Relations Conference was held October 28. This conference was open to all officers and the PR chairmen of the component societies. Speakers from the news media, the AMA, and other areas presented different aspects of public relations. The purpose was to acquaint those present with the various aspects of public relations and communication. This will be a continuing annual affair, and the second conference is scheduled for the fall.

Eldercare

Meeting jointly with the Legislative Committee, plans for the Med-Chi program to publicize the Eldercare program for medical care for the aged were formulated. A professional public relations agency was retained to facilitate our efforts in this area.

House of Delegates Special Session

As a result of the action taken by the House of Delegates, a special assessment was approved. With these funds, which never before have been available to the Faculty, the PR Committee looks forward to implementing an expanded program of communication and education for the membership and the public.

Future Planning

For the future, we plan to establish a Public Relations Council, composed of the PR chairman of each component society, to facilitate closer cooperation and planning of PR activity. The PR Committee of the Faculty will continue to act in an advisory capacity to the PR Council, and the component societies will carry out the major portions of the program. This arrangement together with the assistance of professional help in communication and education should give the Faculty an outstanding communications department which we believe will be outstanding.

Respectfully submitted,
RAYMOND YOW, M.D., Chairman
MANNING W. ALDEN, M.D.
DAVID S. CLAYMAN, M.D.
ROBERT B. GOLDSTEIN, M.D.
JOSEPH H. SEIPP, JR., D.D.S.
E. RODERICK SHIPLEY, M.D.
MRS. W. H. SADOWSKY

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on March 25, 1965, at the Faculty Building. The following members of the committee were present: William G. Helfrich, M.D., Howard F. Kinnamon, M.D., and John G. Ball, M.D., chairman.

All resolutions were discussed and considered fully. Decisions were reached in accordance with the Bylaws, Article X, Section 22.

As has been the custom, your committee will recommend action to the House. The question, however, will be on the resolution itself and not upon the committee report.

Resolution 1A/65†

Submitted on: December 10, 1964
Introduced by: Wicomico County Medical Society
Subject: Incorporation for Professional Persons

Whereas, There is progressive accumulating evidence that the advantages of legislation enabling the incorporation of Doctors of Medicine considerably outweigh the disadvantages of such legislation; and

Whereas, State after state, until more than 30, have come to the same conclusion and have adopted such legislation; and

Whereas, The progressive attempts of the various states to provide increasing safety in this legislation suggest that Maryland could easily study and adopt an acceptable code; therefore be it

***Resolved,* That the Medical and Chirurgical Faculty of the State of Maryland urges the State Legislature to adopt and approve for this State a**

†Resolution not adopted. See minutes.

modern code enabling the incorporation of physicians and surgeons.

In September, 1962, the Policy and Planning Committee reported to the House of Delegates its reasoning behind the Faculty's non-support of legislation which would permit individual physicians to establish professional corporations. These reasons were important enough then and are now to repeat in toto the recommendations of the Policy and Planning Committee. These follow:

INCORPORATION OF PHYSICIANS

There are two ways in which incorporation proposals can be accomplished:

I. In the U. S. versus Kintner, a Montana Association of Physicians was held to have sufficient attributes to permit its classification as an association taxable as a corporation. However the IRS states that the determinations as to whether or not criteria are met depend on State Laws. In Maryland the Uniform Partnership Act would assign to associations characteristics incompatible with the requirements established by the IRS. If this means is used, several facts are apparent:
   1. The group would have to have assurance that the Board of Medical Examiners would not prosecute for violation of the Medical Practice Act.
   2. The IRS only recognizes the Kintner decision in the Ninth Circuit Court District and in fact recent legal cases have suggested that the IRS would not accept this decision.
   3. The IRS can litigate at any time within three years, and if this happened and the IRS won after an extensive litigation, the funds invested in pension plans, etc. would be lost.

II. The Maryland State Corporate Law could be changed to allow the Corporate Practice of Medicine. To accomplish this either a new statute would have to be drafted or the present Corporate Law amended. In either case it would have to be lobbied through the Legislature with the risk of incurring unfavorable publicity. If the Legislature allowed this then a guinea pig Association would have to be formed and its format submitted to the IRS for a ruling. If an unfavorable ruling were obtained then litigation would have to be resorted to.

Comments

In both of the above, a group of physicians would have to meet the criteria for qualifications as a corporation laid down by the IRS and these include:

1. Limited liability.
2. Continuity of life.
3. Centralization of management.
4. Free transferability of interest.

These criteria will face scrutiny by the IRS and there is grave doubt that these could be actually carried out by an association of physicians without impairing many of our cherished precepts, namely:

The responsibility of an individual physician to his patient, and

The possibility of a malpractice suit involving all members of an association to the extent of corporation assets.

It is noteworthy that in January, 1962, the Maryland State Bar Association went on record as opposing any legislation which would permit incorporation of lawyers although they took no stand on other professions. It is understood that the Maryland State Dental Association has also adopted a similar stand.

The Subcommittee feels as follows:

1. The incorporation of physicians by any means would be only for the effect of tax advantage. This advantage, even if obtained, could be wiped out by new legislation at any time.
2. The medical profession is not a business. Personal responsibility for one's own acts is a characteristic of professional status and this would be destroyed by resorting to such tactics to obtain a tax advantage which may be transient.
3. One of the greatest concerns of medicine today is the constant inroads made on the concept that only a physician may practice medicine. If the Medical Practice Act is amended to allow the corporate practice of medicine, we have very little defense against other corporations hiring physicians and practicing medicine.
4. If the incorporation of physicians were approved, the economic factors involved might well force many solo practitioners into group practice—a further infringement of the rights of physicians.

Recommendations:

The Subcommittee is unanimously of the opinion that the Medical and Chirurgical Faculty should not support any such legislation and so recommends to the Policy and Planning Committee.

Further it feels that the Faculty should not support any physician or groups of physicians who are seeking to change the Medical Practice Act with regard to tax advantages.

These recommendations were adopted by the House of Delegates at that time.

Since the adoption of this action by the House of Delegates, nothing has changed to void any of the arguments contained therein. In fact, the Internal Revenue Service has continued to make it difficult for self-employed professional persons to claim the tax advantages under any such type of incorporation.

The *Wall Street Journal* on February 17, 1965, states:

> The IRS has maintained it wouldn't consider professional groups as corporations "merely because the organization was so labeled under local law." And its own requirements for professional groups to qualify for corporate tax treatment have been so stiff, few have been able to meet the test. The Service's rules provide, among other things, that such an organization must have limited liability and a central governing board.

While several bills have been introduced in the Congress to amend the laws and permit such corporations to qualify for preferential tax treatment there is strong doubt that any such laws will be adopted.

Your Reference Committee believes strongly that such attempts to amend state laws would only tend to cloud the issue that this House of Delegates has always strongly opposed, the corporate practice of medicine. To change this philosophy at this time would only weaken our position.

Mr. President, the Reference Committee therefore recommends that Resolution 1A/65 be not adopted.

Resolution 2A/65†

Submitted on: December 11, 1964
Introduced by: George Vash, M.D.
Subject: POLLING OF PHYSICIANS ON SOCIAL SECURITY
(Inclusion of Physicians on a Voluntary Basis under the Social Security System)

Whereas, Many physicians in private practice wish to become participants in the Social Security program (just like employed physicians); and

Whereas, At present this is not possible because of the AMA opposition; therefore, be it

***Resolved,* That the Medical and Chirurgical Faculty of the State of Maryland (go on record in favor of leaving the important decision of whether) POLL ITS MEMBERS AS TO WHETHER THEY WISH to participate or not to participate in the Social Security System. (Up to the individual physician.)**

CAPS portions inserted; parentheses struck out by authority of sponsor

Dr. Vash, the sponsor of this resolution, requested the committee to change his resolution to provide for a poll regarding the feelings of Faculty members on the inclusion of physicians under the Social Security system.

In 1958, the Medical and Chirurgical Faculty conducted such a poll with respect to inclusion of physicians under the Social Security system. In 1961, a similar resolution was considered by this House of Delegates at which time the House again went on record as being opposed to inclusion of physicians under the Social Security system.

The following card was mailed in the Faculty poll in 1958:

† Resolution not adopted. See minutes.

	yes	no
1. Are you in favor of COMPULSORY coverage under the provisions of the Social Security Law?	☐	☐
2. Are you in favor of VOLUNTARY coverage *for yourself* under the provisions of the Social Security Law if this can be accomplished?	☐	☐
3. If the answer to 1 or 2 is "yes," would you still vote "yes" if this coverage were tied to other changes or extension of benefits under the Social Security Law such as Government paid medical care?	☐	☐

4. Age ———— years.

Signature optional

The results were as follows (a total of 2,999 cards were mailed): 1,556 replies (983 from Baltimore City and 573 from counties)

Compulsory coverage	296 yes	543 no	City
	121 yes	368 no	Counties
Voluntary coverage	591 yes	369 no	City
	296 yes	234 no	Counties
If answer to #1 and #2 is *yes,* would you still vote *yes* if this coverage were tied to other changes or extensions of benefits under social security, such as Government paid medical care	125 yes	444 no	City
	68 yes	243 no	Counties

While it can be argued that much has taken place since the 1958 poll that could or would change the thinking of Maryland physicians, much has also taken place with respect to the benefits, as well as the taxes, under the Social Security system.

We often hear physicians comment that they could reduce the amount of life insurance carried by them if they were covered under Social Security. While this may be true, although we doubt the actuarial significance of such an argument, there are many faults inherent in Social Security which make it equally undesirable.

Some of these are:

1. No payments are made if the widow should go to work and *earn* income; investment income does not count.
2. No payments are made to widows before age 62 or for children after the age of 18.
3. There are no funded benefits for payments made into the program.
4. Retirement benefits are not available if earnings are more than $100 per month ($1,200 per year) until you reach the age of 72, when no restriction is placed upon the benefits or earnings. 85% of physicians 65-72 years of age are ACTIVELY PRACTICING, making them ineligible for benefits.
5. The money comes off the top of a person's income, and a tax deduction is not permissible either on state or federal taxes.
6. There are, presently, plans in Congress for increasing the earnings base on which this tax is computed as well as increasing the tax percentage itself. Present legislation pending would make a physician liable for taxes as follows:

1965	259.20
1966	366.80
1971	468.60
1973	498.30
1987	514.80

There is no assurance that these taxes will not be increased even further.

7. Actuarial studies undertaken by interested parties have shown that a physician may purchase sufficient regular life or other insurance that would provide even better benefits, without regard to his or his wife's continued working and their ability to still draw such benefits.

The resolution originally stated that physicians should be covered on a *VOLUNTARY* basis. The only group covered in this manner at the present time are ministers. Members of this group, however, must opt whether or not they wish to be covered and once the option is made they cannot change the option. There is very little likelihood that physicians could obtain a voluntary option for such coverage. In fact, by the time this is considered by our House of Delegates, the Congress may have adopted compulsory coverage for physicians as, at this writing, legislation tied to a health care program is presently under consideration in the Congress.

In view of this, as well as the fact that present federal legislation under consideration in the U. S. Congress and the fact that conducting a poll is not a satisfactory manner in which to ascertain the feelings of the membership.

Your committee recommends that Resolution 2A/65 be not adopted.

Resolution 3A/65†

Submitted on: December 11, 1964
Introduced by: George Vash, M.D.
Subject: Return of Grant of the Tobacco Industry to the AMA

Whereas, The deleterious effects of cigarette smoking have been documented again and again; and

Whereas, It has been reported in the press that the American Medical Association has accepted a substantial grant from the tobacco industry; and

Whereas, The American Medical Association has refused to go along with the planned labeling of cigarettes as dangerous; therefore, be it

***Resolved,* That in order to dispel any appearance of bribery, the AMA and its responsible officers be urged to return the grant of the tobacco industry at once.**

We cannot agree with the third *Whereas.* An officer of the AMA stated that in his opinion the labeling of cigarettes would not solve the problem. The American Medical Association Education and Research Foundation in its report to the AMA House of Delegates in June, 1964, states:

> . . . The Board of Directors of AMAERF and the Board of Trustees of the AMA were clearly aware of the possibility of criticism in accepting this grant. But against that possibility they weighed the potential benefits to the public who will continue to smoke and concluded that the risk was insignificant by comparison.

Also, in the same report, reference is made to the purposes of the AMAERF research project:

> . . . Concern for the problem of smoking and health was

†Resolution not adopted. See minutes.

generated by a growing body of scientific evidence which on the one hand shows that smokers are victims of lung cancer and other diseases significantly more often than non-smokers, but, on the other hand, fails to provide the all-important understanding of *how* and *why* this relationship exists . . .

It is one of the purposes of AMAERF to ascertain the how and the why.

The AMA has appropriated from its own funds the sum of $500,000 to get this project under way. It also made known that it would accept unrestricted funds from six tobacco companies to assist in financing a program of research on tobacco and health.

The conditions under which such funds were accepted are as follows:

1. Contributions will be used to assist in the support of research on tobacco and health. The Board of Directors of the AMAERF shall have the sole responsibility of determining the merits of each research proposal and whether it properly comes within the scope of this project.
2. Contributions will be transmitted to the AMAERF in five substantially equal annual installments from 1964-1968, with the provision that, if at any time any part of the remaining unreceived funds is not needed or cannot be usefully spent for the purpose intended, the companies shall be notified so that further and future contributions can be reduced proportionately. It is our understanding that at no time will any money actually received by the AMAERF for this purpose be refunded to the contributor.
3. While contributions will be received in approximately level amounts, it is likely that the amount of funds committed or expended annually by AMAERF will vary from year to year. In keeping with this general expectation, the companies will be kept advised of the progress of this project and will be informed annually of the financial needs for the next year.

Had the author of this resolution taken the time to ascertain the facts in this particular matter, it would have been readily apparent that the AMA while, perhaps, subject to criticism in accepting such funds, laid down specific terms and conditions under which they would be accepted and appropriated its own funds for the same purpose.

In addition, the AMA is ascertaining the how and why of the causal relationship of tobacco and health rather than repeating the studies of the Surgeon-General's special committee.

In the light of the above, **the Reference Committee recommends that Resolution 3A/65 be not adopted.**

The Reference Committee wishes to thank those who took the time to appear before it, as well as the committee members and the office staff for their research and assistance in preparing this report.

Your committee also again urges individual members as well as members of the House of Delegates to take advantage of the opportunity of appearing at the meeting and expressing themselves on the subjects under discussion.

Respectfully submitted,
JOHN G. BALL, M.D., chairman
EVERETT S. DIGGS, M.D.
WILLIAM G. HELFRICH, M.D.
W. ROYCE HODGES, M.D.
HOWARD F. KINNAMON, M.D.

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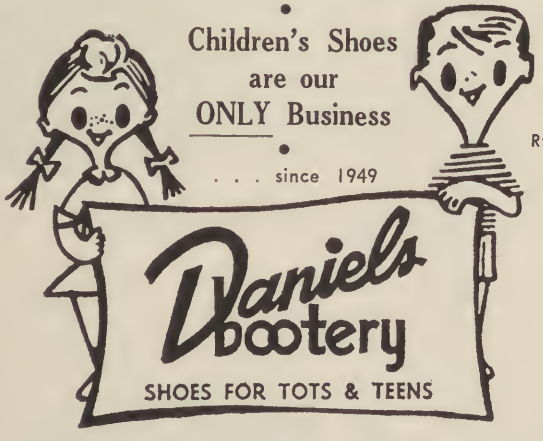


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COMPONENT MEDICAL SOCIETIES

Baltimore County

The Penn Hotel, Towson, was the scene of the Baltimore County Medical Association's June 16 meeting. The president, **John Snyder, MD,** introduced and welcomed **Mrs. Martin Strobel,** president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. He also welcomed the members of the Woman's Auxiliary to the Baltimore County Medical Association.

Mrs. Samuel Wells, president of the County Auxiliary introduced **Miss Linda Joyce Watkins** and her mother. Linda has been accepted at the Maryland General Hospital, School of Nursing, on a scholarship which was presented by the Woman's Auxiliary.

J. Morris Reese, MD, presented the Doctor of the Year award to **Donald Roop, MD,** who responded with thanks.

Donald Roop, MD, chairman of the Liaison Committee, recommended that the Association support the Baltimore County Health Department and Board of Health in Operation Head Start.

Jonas Rappeport, MD, proposed the following resolution and moved its adoption:

WHEREAS, it has been made clear that at least one county medical society has excluded a qualified physician from membership because of color alone, and

WHEREAS, the American Medical Association's House of Delegates has clearly opposed any discrimination of medical personnel in medical societies, hospitals, committees, etc., because of race, color, or creed,

WE RESOLVE that the entire membership of any county medical society that excludes a qualified physician from membership because of race, color, or creed be disenfranchised from the state medical society and lose all privileges of such association within 30 days of the passage of this bill.

This motion was lost.

The following amendment to the Bylaws was passed by the Association:

Article II Section 2 Dues—add new sentence to Paragraph A—

A. The annual dues of active members shall be $30.00 per year plus the appropriate dues and assessment of the Medical and Chirurgical Faculty. Upon the recommendation of the Board of Governors and at least fourteen days notice to all active members, the Association in session may impose an assessment in addition to dues to be paid with, and in the same manner, as dues by all active members.

Delete Paragraphs H and I of article II Section:

The Board of Governors shall set the salary of the Executive Secretary at the meeting immediately following the annual meeting.

Dr. Snyder gave his farewell message entitled "The Image of the Doctor." An election of officers was held, and the following were elected: president, **Edward L. Krieg, MD;** vice-president, **Edward G. Grau, MD;** secretary-treasurer, **S. J. Venable, Jr., MD;** delegates, **John Snyder, MD, Thaddeus Siwinski, MD, Donald Wood, MD, Martin Strobel, MD,** and **Charles H. Williams, MD;** alternates, **Kent Robinson, MD, Henry McCorkle, MD, Theodore Patterson, MD, Robert Ensor, MD,** and **John Darrell, MD.**

A gavel and Hocking cane was presented to Dr. Krieg and a past president's certificate to **Dr. Snyder.**

⚙ *Charles H. Williams, MD*

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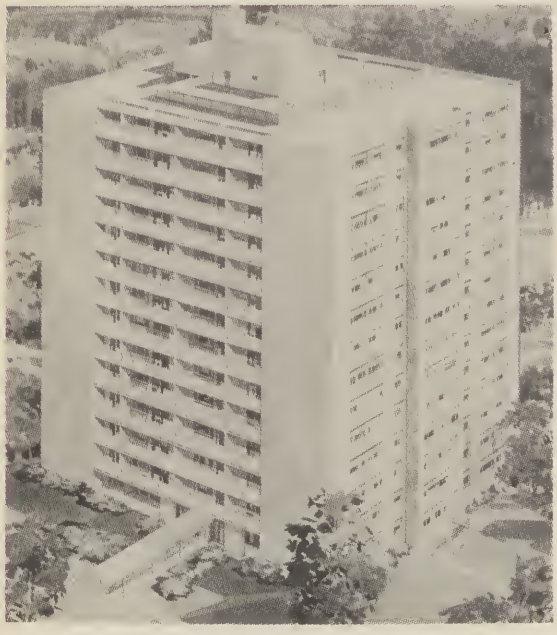
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EXFOLIATIVE CYTOPATHOLOGY;

A CURRENT APPRAISAL

M. WILSON TOLL, MD

IN THE MAY, 1962, ISSUE OF THE *Maryland State Medical Journal*, Dee gave an excellent summary of the history and then current status of clinical cytopathology. Since then, the role of exfoliative cytopathology in the diagnosis of neoplastic disease has been further consolidated. Its value in areas other than detection of malignancy has been further explored. A reappraisal seems appropriate at this time.

Without question, cytopathologic techniques offer a reliable means of diagnosis of early carcinoma of the uterine cervix and, therefore, a means of controlling that disease. However, application of the acquired knowledge still leaves much to be desired, as evidenced by the estimated 14,000 deaths from cervical cancer in the United States in 1965. In part this may reflect public apathy and resistance, essentially a problem of health education. Pilot studies of mass screening clinic programs have demonstrated their value but are still limited in application. The aspiration smear technique is under study in Maryland and elsewhere. If proved practical and acceptable, it will make cytopathologic screening available to a larger segment of the female population, particularly in areas of physician shortage.

Screening programs assume an adequate supply of trained physicians and technicians for proper study of cytopathologic material. Automated slide screening procedures are being evaluated but are not yet sufficiently advanced for practical use. Therefore the cytopathologist must rely on the assistance of trained cytotechnicians for screening large volumes of material. Continuing training programs for professional and technical personnel are mandatory if maximum benefits of cytopathology are to be realized.

In cancer detection in sites other than the cervix there has been definite clarification of the role of cytopathology since 1962. The cytopathology of lung cancer is well documented, and cytopathologic techniques are of known value in this area. Efforts in this field are now being directed toward increasing technical efficiency of processing and screening of specimens. Screening programs for high risk groups have been advocated but rarely undertaken because of cost in time and money. These remain possibilities for the future.

Cytologic study of cells exfoliated from the urinary bladder has been proved valuable in detecting early bladder cancer. A carcinoma in situ phase of this tumor has been established by cytopathologic studies. How frequently such a phase may be recognized and its relation to therapy and prognosis awaits further study.

Diagnosis of early asymptomatic cancer of the stomach is possible by cytologic methods but lags in practical application because of rigorous demands of technique. Cytopathology of oral lesions has been well studied since 1962, but its place as a screening procedure is still undecided.

Since 1962 significant advances have been made both in detection of malignancy and in recognition of non-neoplastic disease. These have come about as the result of cooperative and progressive attitudes of clinicians, as advocated by Dee in 1962. Whether or not maximum benefit is to be derived from application of technical knowledge depends on the attitudes of the practicing physician and public and private health agencies. Adequate recruitment and training programs for cytopathologists and cytotechnicians must be maintained, perhaps even expanded. It is to be hoped that those responsible for organization and financing such training programs will recognize the need.



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The Heart Page

Ralph Weber, MD—*Editor*

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DIET AND HEART DISEASE

THE DEVELOPMENT OF ATHEROSCLEROTIC coronary heart disease, the basis of most heart attacks, is influenced by several factors. Scientific studies have provided increasing evidence that diet is one of the more important of these factors.

Because of the enormous public health importance of coronary heart disease and the growing likelihood that suitable measures will reduce its toll, the American Heart Association has a responsibility to inform the public concerning the relationship between diet and coronary heart disease and to provide the best advice currently available.

In January, 1961, the Association issued a report on "Dietary Fat and Its Relation to Heart Attacks and Strokes." Since that time, additional scientific data have accumulated based upon many different kinds of research studies. These findings indicate that appropriate dietary control may contribute to the retardation or prevention of coronary heart disease. The Association has accordingly asked its scientific advisors to prepare an up-to-date statement focusing on the coronary heart disease problem.

This statement was issued by The American Heart Association on June 5, 1965, at the Board of Directors meeting (drafted by the Nutrition Committee). Two booklets pertaining to "Planning Fat Controlled Meals" can be obtained from the Heart Association of Maryland. Diets of unrestricted calories and for restricted calories (1,200, 1,800) are available to physicians upon request or may be sent directly to patients at the specific request of the physician.

One approach to the retardation or prevention of coronary heart disease through dietary control is based on the concept that lowering the concentration of cholesterol and other blood fats may lower the risk of developing coronary heart disease and heart attacks. Studies of population groups in the United States and elsewhere have disclosed an association between the level of cholesterol and other fats in the blood and the incidence of coronary heart disease. Thus, populations with a low concentration of cholesterol and other blood fats have a lower incidence of coronary heart disease than populations with higher concentrations. These findings are of importance because a relationship has been demonstrated between the habitual diet and the concentration of cholesterol and other fats in the blood. It has also been shown that in most persons, but not all, the level of cholesterol and other fats in the blood can be decreased and maintained at a lower value by conscientious and long-term adherence to a suitable diet. In most individuals, this would entail:

1) A significantly decreased intake of saturated fat;

2) A significantly increased intake of polyunsaturated fat, with polyunsaturated fats being substituted for saturated fats in the diet wherever possible;

3) A decreased intake of cholesterol-containing foods;

4) A caloric intake adjusted to achieve and maintain desirable weight.

(Statistical evidence strongly supports a relationship between coronary heart disease and both hypertension and diabetes mellitus. Since obesity aggravates both of these conditions, it is reasonable to strongly recommend control of weight as well as careful management of high blood pressure and diabetes.)

It is noteworthy that dietary modifications based upon the principles described above have been used by many adults for almost a decade without clinical or biochemical evidence of deleterious effects. The public is therefore advised:

1) To eat less animal (saturated) fat;

2) To increase the intake of vegetable oils and other polyunsaturated fats, substituting them for saturated fats wherever possible;

3) To eat less food rich in cholesterol;

4) If overweight, to reduce caloric intake so that desirable weight is achieved and maintained;

5) To apply these dietary recommendations early in life;

6) To maintain the principles of good nutrition, which are important with any change in the diet. Professional nutritional advice may be necessary in order to assure that correct adherence to the diet will not result in any imbalance or deficiency;

7) To adhere consistently to the above dietary recommendations, so that a decrease in the concentration of blood fats may be both achieved and maintained;

8) To make sound food habits a "family affair," so that the benefits of proper nutritional practices—including the avoidance of high blood fat levels—may accrue to all members of the family.

Other factors may increase the risk of developing coronary heart disease. These include hypertension, diabetes mellitus, cigarette smoking, lack of exercise, and others. As in the case of diet, these factors may be corrected or controlled by programs based upon advice from the family physician.

The American Heart Association recognizes its responsibility to inform and advise the public about the potential benefits of diet modification, but it also recognizes the great and continuing need for additional research in the prevention and control of coronary heart disease.

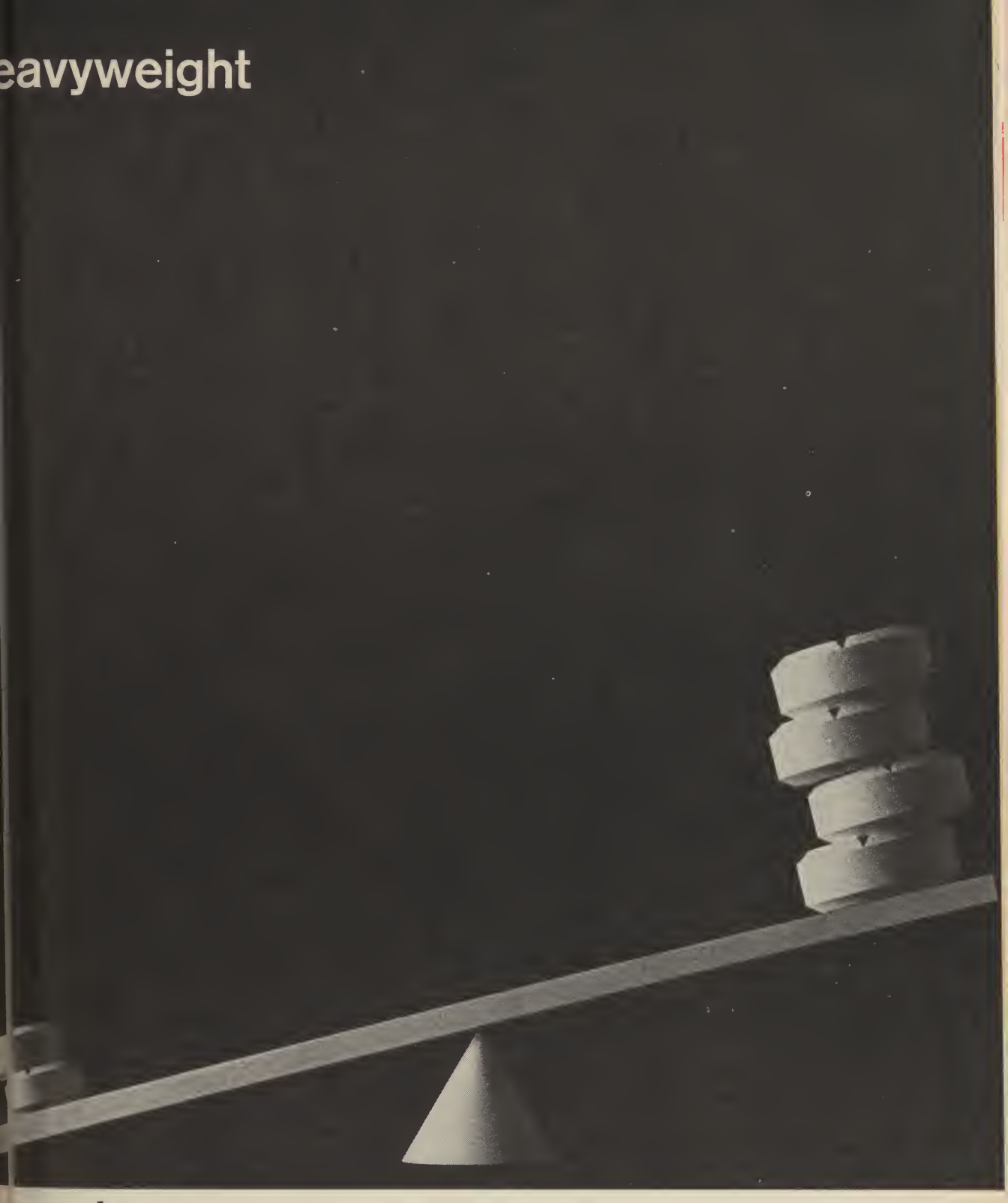
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*Swartz, C., et al.: Circulation 28:1042, 1963.

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EXCRETORY UROGRAPHY AS A SCREENING PROCEDURE IN THE DIAGNOSIS OF RENOVASCULAR HYPERTENSION

JOHN M. DENNIS, MD
University Hospital

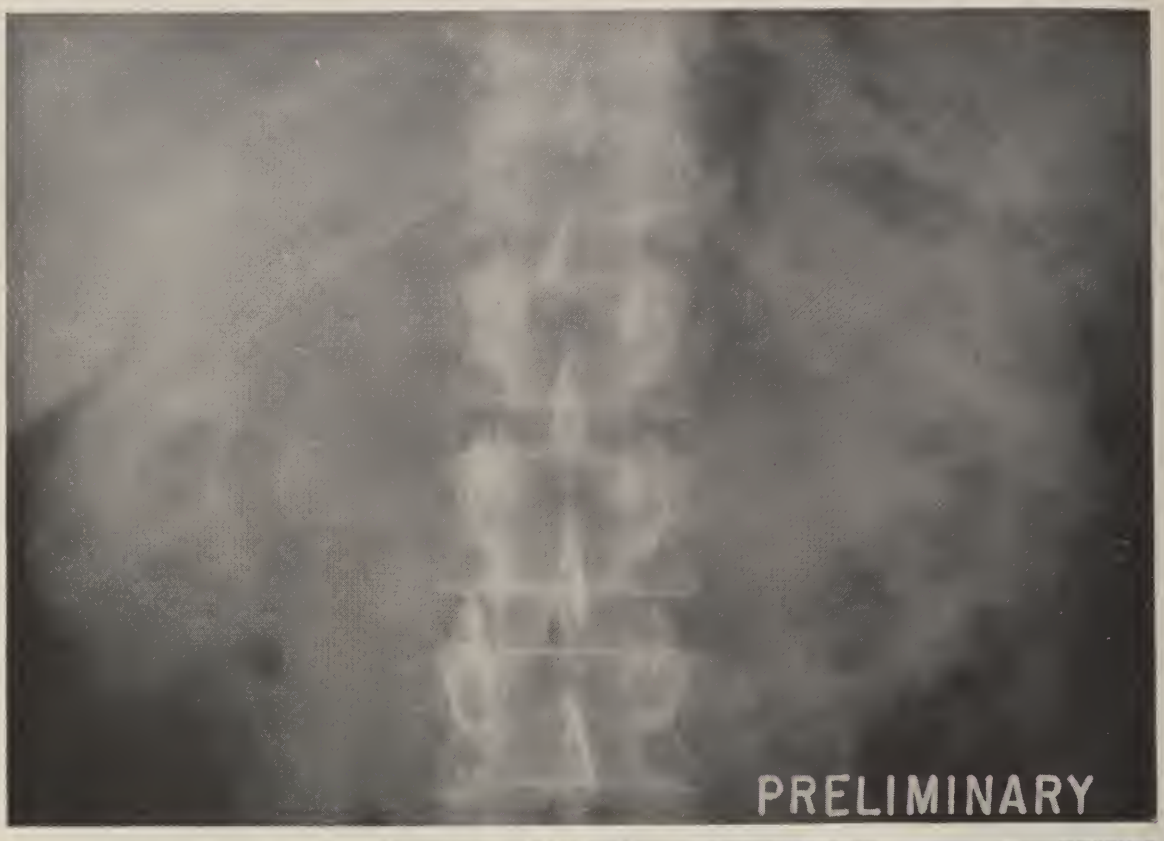
Occlusive disease of the renal arterial vasculature will produce hypertension which clinically may simulate essential hypertension. Since some cases of hypertension due to renal artery occlusive disease are curable, it is imperative that all hypertensive patients be screened to determine those who may possess this abnormality. Several diagnostic procedures are available to determine whether a renovascular lesion is responsible for a specific case of hypertension, but most of these are too time consuming to be used in each case. A well performed and carefully interpreted excretory urogram is a simple but reliable screening procedure, which is about 90% to 95% reliable in determining whether the hypertension has a renovascular basis.

The technique of excretory urography used in surveying hypertensive patients differs from the ordinary excretory study, in that 50 cc of contrast material is rapidly injected and then serial studies are made at 15 seconds and at one minute intervals for the first five minutes in order to obtain a nephrographic effect in the kidneys and to study the appearance time and differential excretion of the opaque medium. The conventional initial five minute study, which is used by most physicians and radiologists, will not allow one to determine the subtle initial delayed appearance of the contrast medium. Routine studies are then obtained at 10, 15, and 30 minutes after injection.

The main excretory urographic findings in the renal artery occlusive disease are 1) decreased size of the affected kidney and 2) delayed and impaired excretion of the opaque medium in the affected kidney (figs 1 and 2).

Renal ischemia usually results in a decrease in the size of the involved kidney or a segment thereof. In evaluating kidney size, however, one must remember that the left kidney is usually about one centimeter longer than the right. A difference of more than one centimeter suggests renal artery stenosis. Any disparity in the contour of the kidneys can best be determined from the nephrographic effect of the kidneys which is documented on the 15 second study. While the ischemic kidney is usually smaller, its outline is usually smooth unless there has been segmental infarction, in which case the infarcted segment may be somewhat irregular. The pyelonephritic kidney, is not only smaller but usually more irregular in contour.

In studying the appearance time and the differential excretion of contrast medium by the kidneys during excretory urography, the early serial studies made at 15 seconds and at one minute intervals for the first five minutes are important. Decreased nephrographic effect in the involved kidney may be determined on the 15 second study,


PRELIMINARY


2 MINUTES

Fig. 1

Preliminary study reveals the right kidney to be smaller than the left. The right kidney measured 12 centimeters in length as compared to 14.2 centimeters for the left.



Fig. 3

A five minute study reveals equal concentration of the contrast material in the two kidneys.



Fig. 4

A 30 minute study reveals increased concentration of the contrast material in involved right kidney.

and subtle initial delayed appearance and diminished excretion of the contrast material in the collecting system may be detected in the ischemic kidney in the two, three, and four minute study (fig. 2). This delayed nephrographic effect and differential excretion of the contrast medium is related to decreased plasma flow in the ischemic kidney. Depending upon the severity of renal damage, this delayed and diminished excretion of the contrast medium may not be apparent on the five minute study, as, by this time, the contrast medium will usually be of equal or even higher concentration in the collecting system of the ischemic kidney. This is because water resorption is greater and the urine flow slower than in the normal kidney (figs 3 and 4).

The kidney affected by arterial occlusive disease is inherently unable to produce dilute urine because of increased tubular reabsorption of water. Advantage may be taken of this fact by maximally hydrating the patient at the end of the routine study with several glasses of water and

Fig. 2

A two minute study reveals diminished excretion by the right kidney in comparison to the left one.



Fig. 5

Percutaneous transfemoral arteriogram reveals marked narrowing of the right renal artery (arrow) by an arteriosclerotic plaque.

then obtaining further serial studies at 30 minute intervals for approximately 90 minutes. In the maximally hydrated state, the contrast material will remain in the involved kidney and may become hyperconcentrated because of increased water reabsorption and decreased urine flow, whereas it will be "washed out" of the collecting system of the normal kidney. A similar radiographic effect may be produced in a patient with renovascular hypertension by diuresing the patient with intravenous urea.

Two other radiographic findings of value have been described: 1) persistent unilateral delicacy and thinning of the collecting system in the ischemic kidney, the so-called low volume collecting system, and 2) "notching" of the ureter of the involved kidney, produced by the development of collateral blood supply to the kidney from the ureteric arteries which form a plexus around the ureter.

SUMMARY

A well performed and carefully interpreted excretory urogram is an excellent screening procedure to determine whether a case of hypertension is caused by occlusive disease of the renal arterial vasculature. Radioactive renograms, individual renal function studies, and renal arteriograms are important confirmatory procedures which provide more specific information and allow for more definitive planning of therapy (fig 5).

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EDITOR

Recent Advances in the Rehabilitation of Rheumatoid Arthritis

RHEUMATOID FACTOR

ALEXANDER S. TOWNES, MD
Department of Medicine,
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DURING THE PAST DECADE much of the research in rheumatoid arthritis has been devoted to the study of immunological aspects of the disease and particularly to the nature and role of rheumatoid factor. Although the cause of rheumatoid arthritis has yet to be discovered, a great deal has been learned about both the nature and the origin of rheumatoid factor and about the underlying immune mechanisms themselves. In addition, from the practical standpoint, the significance of the clinical demonstration of rheumatoid factor has been well clarified. This review will attempt to summarize briefly some current concepts about rheumatoid factor. (For more complete reviews and bibliography, see references 1, 2, 3, and 4.)

Many lines of evidence point to rheumatoid factor as representing antibody to gamma globulin. Structurally, rheumatoid factor belongs to the 19S macroglobulin class of immunoglobulins. It has a heterogeneous electrophoretic mobility with the rapidly migrating gamma globulins (γ 1M or β 2M) as well as other physical and chemical properties identical with those of macroglobulin antibodies. Rheumatoid factor thus cannot be distinguished from other antibodies of its class except on the basis of its specific reactivity with antigen. Also in keeping with the conclusion that rheumatoid factor is antibody is the fact that the site of origin of rheumatoid factor has been demonstrated by immunofluorescent techniques to be the plasma cells of the inflamed synovium, regional lymph nodes, or spleen of patients with rheumatoid arthritis.

The antibody nature of rheumatoid factor implies that it is produced as the result of antigenic stimulation. What antigen is responsible for its production, and where and how does it arise? The answers to these questions cannot be given with certainty at the present time. Considerable evidence favors the notion that the substance which stimulates production of rheumatoid factor is autologous 7S gamma globulin whose molecular structure has been sufficiently altered from the native state to render it antigenic. Thus, except under certain conditions, native gamma globulin fails to react as antigen in *in vitro* tests for rheumatoid factor, whereas gamma globulin denatured by heat or other means is highly reactive. Antibodies produced by injection of altered autologous gamma globulin in experimental animals show reactivity similar to that of rheumatoid factor, including cross reaction with gamma globulins of other species. The specificity of rheumatoid factor for antigenic groups found on autologous gamma globulin has also been demonstrated with special techniques in some sera.

One may speculate from the intense localization

of rheumatoid factor-producing plasma cells in the synovial membrane that one likely source of the antigenic stimulus is the inflammatory synovial reaction itself. Gamma globulin of the 7S type, along with other serum proteins, enters the synovial fluid with inflammation and has also been found deposited in the synovium. Whether the latter localization is peculiar to rheumatoid arthritis or involves specific antibody localization, however, has not been fully clarified.

The conditions or circumstances responsible for the alteration of gamma globulin to make it antigenic also remain obscure. One attractive hypothesis holds that 7S gamma globulin antibody may become antigenic as a result of changes in molecular structure which occur as a result of its own combination with antigen. According to this theory, rheumatoid factor may result from prolonged exposure to altered antibody globulin in antigen-antibody complexes of as yet undetermined type. Indeed, rheumatoid factor-like antibodies have been induced in experimental animals by repeated and prolonged stimulation with common bacterial antigens. In addition, the frequent clinical occurrence of positive tests for rheumatoid factor in patients with leprosy, syphilis, tuberculosis, subacute bacterial endocarditis, and in aged individuals lends some support to the concept that rheumatoid factor may result from sustained antigenic challenge.

Whatever its mechanism of production, there is substantial evidence that rheumatoid factor represents a reaction to the disease process and is not a primary cause of rheumatoid arthritis. It is less certain whether rheumatoid factor plays any secondary pathogenic role in the disease. The possibility that rheumatoid factor complexes may be involved in the production of arteritic lesions which occasionally complicate the course of rheumatoid arthritis has been suggested but not proven. Participation of rheumatoid factor in the synovial inflammatory process has also been postulated recently, as a result of the demonstration of inclusions containing rheumatoid factor within phagocytic leukocytes in rheumatoid synovial fluid, and the induction of inflammation in a quiescent joint by the injection of isolated autologous gamma globulin.[5–7] The role of rheumatoid factor in these reactions, however, has not yet been established.

The most widely available tests for clinical detection of rheumatoid factor are the latex fixation or bentonite flocculation tests, which depend upon the capacity of rheumatoid factor to produce agglutination of inert particles coated with human gamma globulin. The RA (Hyland) slide test modification of the latex test is widely used and is an excellent screening device since it is simple to perform and has few false negatives. There are many false positives, however, as compared to the tube dilution latex test. In addition, determination of titer, which is accurate only with the tube dilution method, is valuable in interpretation of results. Thus, the standard latex or bentonite test should be carried out on all sera which are positive or doubtful on the screening slide test. The sensitized sheep cell agglutination test (SCAT, Rose-Waaler test) depends on the reactivity of rheumatoid factor with rabbit antibody globulin on sensitized sheep cells. Reaction with rabbit gamma globulin is common with rheumatoid factors in rheumatoid sera and is much less common in other disorders associated with rheumatoid factor activity. Thus, despite its somewhat lesser overall sensitivity, the SCAT is still useful clinically because of its greater specificity for rheumatoid arthritis.

A number of clinical facts about rheumatoid factor seem to be well established. Not all patients with rheumatoid arthritis have rheumatoid factor in their serum, but virtually all of those with the classical adult disease associated with subcutaneous nodules will have positive test findings. The overall incidence of positive latex fixation test findings is 70 to 85% in patients with rheumatoid arthritis which is definite or classical by ARA criteria. When rheumatoid factor is present, it tends to be present early in the course and to persist thereafter independent of disease course and activity. The development of a positive test after six months or a year of symptomatic disease is also not uncommon. Reversion to negative occasionally occurs with grade 1 remissions. There is some correlation of moderate or high titers of rheumatoid factor with sustained disease, development of bone destruction, systemic granulomata, and a generally poorer prognosis as compared to those with low titers or negative findings. There are many individual exceptions. The diagnosis of arteritis due to rheumatoid disease is virtually excluded in the absence of rheumatoid factor.

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arthritis have a low incidence of rheumatoid factor (about 20%) by standard tests. Patients with arthritis due to Reiter's syndrome, psoriasis, ulcerative colitis, or ankylosing spondylitis have negative rheumatoid factor tests; indeed, this fact has been most helpful in defining clearly these disorders as separate diseases from rheumatoid arthritis. Positive tests are by no means confined to patients with rheumatoid arthritis but are present most commonly and abundantly in this disease. Positive rheumatoid factor tests may also develop in a variety of chronic infections, liver disease, collagen diseases, idiopathic pulmonary fibrosis, sarcoidosis, in aged or occasionally even in young healthy persons. Thus, rheumatoid factor usually indicates some abnormality, but its presence even in high titer is not inconsistent with good health.

Early reports of family studies suggested the possibility that the capacity to develop rheumatoid factor might be genetically determined because of increased incidences among family members of patients with rheumatoid arthritis. More recent surveys of populations with careful statistical methods, however, have failed to show any difference in families of rheumatoid arthritics as compared to controls, either with respect to the incidence of the disease itself or the occurrence of rheumatoid factor. Yet it is clear that striking clustering of cases or positive test results are occasionally encountered within some families. Explanation of these occurrences requires further exploration.

REFERENCES

1. Vaughan, J. H.: Serum responses in rheumatoid arthritis. *Amer J Med* 26: 596, 1959.
2. Vaughan, J. H., and Butler, V.P.: Current status of rheumatoid factor. *Ann Intern Med* 56:1, 1962.
3. Christian, C. L.: The rheumatoid factors. *J Chron Dis* 16:875, 1963.
4. Transactions of the Conference on the Immunological Aspects of Rheumatoid Arthritis and Systemic Lupus Erythematosus. Princeton, New Jersey. *Arth Rheumat* 7:401, 1963.
5. Hollander, J. L.; McCarty, D. J.; Astorga, G.; and Castro-Murillo, E.: Studies on the pathogenesis of rheumatoid joint inflamation. I. The "R.A. cell" and a working hypothesis. *Ann Intern Med* 62:271, 1965.
6. Rawson, A. J.; Abelson, N. M.; and Hollander, J. L.: Studies on the pathogenesis of rheumatoid joint inflammation. II. Intra-cytoplasmic particulate complexes in rheumatoid synovial fluids. *Ann Intern Med* 62:281, 1965.
7. Restigo, et al: Studies on the pathogenesis of rheumatoid joint inflammation. III. The experimental production of arthritis by the intra-articular injection of purified 7S gamma globulin. *Ann Intern Med* 62:285, 1965.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

A MEDICAL BLACKOUT

MARVIN A. BLOCK, BS, MD

Is a physician well trained if he is unable to diagnose and adequately treat a disease that affects 6 per cent of the total adult population? Is medical practice satisfactorily served when a disease occurring in one of every 15 adults is neglected in both diagnosis and treatment by otherwise qualified physicians? Is a general hospital which denies admittance to patients with this prevalent disease a proper place for the training of interns and residents who later will care for the general public? Most physicians would shrink from the idea that this is possible. Yet alcoholism, a very insidious disease, is avoided by many physicians and is often reason for denial of admission to many hospitals. Far too often it is overlooked by practicing doctors who see these patients every day.

Many interns and residents have never treated people suffering from alcoholism by the time they complete their training at their hospitals simply because the hospitals have denied admission to such patients. If these patients are sometimes admitted, it is often with a subterfuge diagnosis, and the attention of interns and residents is thus misdirected so that the importance of the alcoholic is minimized.

For too long the stigma attached to alcoholism has been accepted by many physicians. Instead of accepting the responsibility for treatment, doctors often refer alcoholics to laymen for care. The frustration resulting from failure to produce good results often accounts for this attitude. This frustration could be avoided if the same attention were given to the study of alcoholism as is given to other diseases.

Many patients avoid divulging information helpful to a physician in making a proper diagnosis, but this also stems from fear of the stigma of the alcoholic label. The opprobrium of being labeled or fear of withdrawal from the drug upon which he is dependent leads to denial and rationalization so characteristic of the excessive drinker. But this characteristic is part of the disease. Consider the chagrin of the physician who had overlooked a diagnosis of tuberculosis, peptic ulcer, or diabetes only because his history taking had been inadequate—even though the patient had appeared for treatment of another condition. It is not unusual for a patient to blame a cough on smoking, to deny that he eats excessively or his fluid intake is unusual, or that gastric distress occurs more often than he admits. In these cases, however, the physician pursues with relentless energy the minutest signs and symptoms that would help him make a diagnosis.

But the elicitation of the history of the drinking pattern of his patients is often limited to "Do you drink?" and "How much?" The physician rarely goes into the details with diligent inquisitiveness, nor does he routinely check the liver function tests and the enlarged organ itself; alcoholism, of

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course, can exist without these positive signs. He fails to check the drinking history with other members of the family to ascertain how truthful the patient has been. Too infrequently does he inquire about the relationship of emotional tensions and drinking. Unfortunately, even when told that the patient does drink considerably, he often passes it off as of little importance. He hesitates about obtaining details of drinking when the patient seems to resent questioning.

Alcoholism represents one of our great public health problems. The family physician should be constantly aware that a patient who comes to him for advice may be in the early stages of this disease. He should exhaust every effort to ascertain whether alcoholism is present, particularly if the patient exhibits signs or symptoms of anxiety, tension, or nervousness. Should he suspect it at all, there are many ways available to him for motivating the patient to accept treatment, to re-educate him toward a life of abstinence, the only successful method of meeting this problem. This should not be done by sitting in judgment upon the patient nor by adopting a "holier than thou" attitude. It must be done by objective and clear thinking in the same manner that the physician approaches other diseases.

Once he has applied himself to the study of this illness, which affects not only the individual but the family and community as well, there is no one better qualified to handle this problem than the doctor. The unusual case, the more difficult and complicated problems, or those involved with an underlying psychosis may require a specialist, but the greatest number of patients fall within the realm of general medical practice.

Both the American Medical Association and the American Hospital Association have urged physicians and hospitals to treat these patients as they would other sick people. Unfortunately, the threat which this disease presents has not been met adequately. With no other illness would the medical profession be content to shift responsibility to lay people. Alcoholics need and deserve from their physicians the best medical attention. This responsibility presents a challenge which physicians must meet.

Pediatrics

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WILLIAM STIFLER, JR., M.D., Chairman

RAY HEPNER, M.D., Editor

Recent Advances in Pediatrics–Rubella

ALEXANDER J. SCHAFFER, MD

ONE OF THE MOST FRUITFUL advances in pediatrics in the past few years has concerned German measles. It began in 1962 with the simultaneous discovery by two groups of investigators of methods whereby rubella virus can be grown. Virologists for many decades had been frustrated by this problem, and a mass of badly needed information cascaded over this finally broken barrier.

It became clear that the rash which followed exposure to rubella was preceded by viremia, which lasted about five days, then lasted a variable time after the exanthem erupted. Neutralizing antibodies to the virus appeared in the blood within a few weeks. But it also became clear that a significant proportion of exposed individuals developed antibody without ever having manifested a rash. This had been suspected, but its unequivocal demonstration was of great significance to the most important facet of fetal rubella infection.

The disease in the child and adult is ordinarily of little moment. By and large the overwhelming importance of rubella lies in its effect upon the embryo and fetus when a woman acquires the disease in the first trimester of pregnancy.

Up to this time it was not known whether the congenital defects which ensued resulted from interference with nutrition or from actual infection of the embryo. The new cultural technique answered this question quickly and with surprising overtones. Both the placenta and the embryo were heavily infected with virus during the course of maternal rubella. The surprise came in the discovery that fetal infection is not self-limited as it is in postnatal infection, that is, that virus can be grown not only from aborted embryos but also from fetuses stillborn later in pregnancy and from living newborns delivered at term! Many liveborns continue to harbor virus in the nasopharynx, in the urine, and in many tissues for months after birth.

The paradox is that virtually all these infected infants develop a high titer of neutralizing antibody in their blood. In spite of this, virus continues to multiply in their bodies.

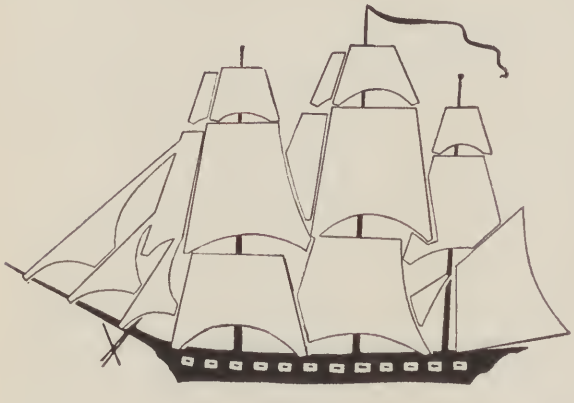
What have we learned that is of diagnostic and therapeutic importance? First, we can delineate more certainly the clinical pictures resulting from fetal infection. In the wake of the last epidemic of German measles we are encountering two manifestations in newborns which we have never before associated with fetal rubella. One is congenital glaucoma, quite unlike the cataracts which we had always thought of as the ocular lesion expected after maternal disease. The other is congenital thrombocytopenia, usually accompanied by hepatosplenomegaly, producing the aptly named "blueberry muffin" baby.

Second, we can now demonstrate retrospectively whether or not rubella virus had been the teratogenic agent when an infant is born with

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congenital malformations. Finding the virus or demonstrating neutralizing rubella titer can substantiate this point. Even more important is finding rubella antibody in the blood of older infants and children with hearing loss. It appears that this is indeed the explanation for deafness in many children who have had none of the other manifestations of the fetal rubella syndrome.

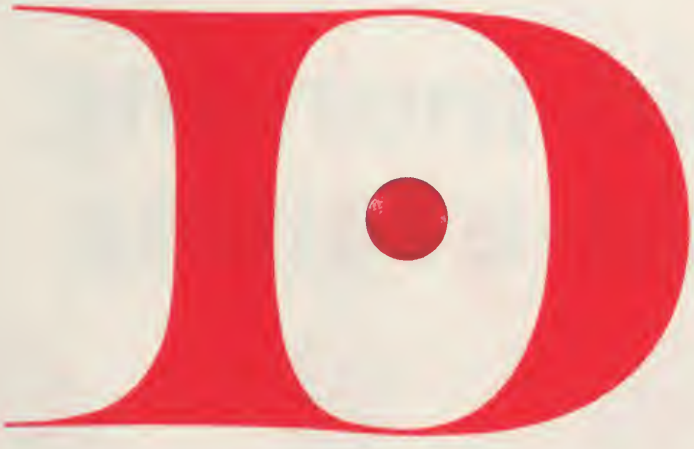
Third, these discovered facts have made our course somewhat clearer with respect to the advice we give to mothers who are exposed to or acquire rubella in the first trimester of pregnancy. If a mother acquires the disease in an epidemic year the chances of her baby's being born defective may be as high as 40% if she becomes ill in the first month, as low as 10% in the third month. (In nonepidemic years the probability of untoward outcome is probably much smaller.) On the basis of these probability figures she should be allowed to make her own choice as to whether she wants a therapeutic abortion or not. If she chooses abortion, it should be performed. Gamma globulin is of no use once the rash has appeared, since viremia has already been present for several days.

If she has been exposed to someone with rubella early in pregnancy, what should be done? We now know for certain that a history of having had rubella or not cannot be relied upon. Furthermore, gamma globulin may or may not protect her. Many batches of gamma globulin contain little antirubella antibody, some contain more. Besides, the material may only render a case inapparent but still hazardous to the fetus. Nevertheless it may in some instances prevent viremia, hence fetal infection. Therefore our policy should probably be to 1) wait to see if she develops the disease, if she will be aborted if this happens, or 2) give her 20 cc of gamma globulin if she will not be aborted even if she comes down with it.

I look forward to the day when physicians will perform antirubella antibody studies on all girls before marriage. And soon, hopefully, a vaccine will be available for those girls who have not acquired antibody prior to this.

Finally, we must be careful about babies born with congenital defects. These may have resulted from fetal rubella, and the infants may be excretors of virus. Such babies have already been known to spread the disease to nurses and attendants. At least one nurse so infected was in the early stage of pregnancy.

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INDICATIONS: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

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Staphylococci
Streptococci

Evaluation in other infections and conditions is continuing.

DECLOMYCIN Demethylchlortetracycline is indicated for surgical and dental preoperative and postoperative prophylaxis of infection in contaminated fields. Since penicillin is the drug of choice for syphilis and gonorrhea, it should be employed in these infections except in patients with a history of penicillin allergy.

In cases of acute gonococcal urethritis where a primary or secondary lesion of syphilis is suspected, proper diagnostic procedures including darkfield examination should be followed. In all other cases where concomitant syphilis is suspected, serological tests should be made monthly for at least three months.

In patients with agammaglobulinemia or hypogammaglobulinemia and recurring infections, it is necessary to treat with both gamma globulin and an antibiotic such as DECLOMYCIN Demethylchlortetracycline.

DECLOMYCIN Demethylchlortetracycline shows *activity* against some strains of *Pseudomonas* and *Proteus* heretofore unresponsive to tetracycline therapy as shown by both *in vivo* and *in vitro* studies.

In the treatment of staphylococcus infections, indicated surgical procedures must be performed in all cases.

WARNING: If renal impairment exists, even usual oral or parenteral doses may lead to excessive systemic accumulation of the drug and possible liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, demethylchlortetracycline serum level determinations may be advisable.[1,2,3]

A photodynamic reaction precipitated by direct exposure to natural or artificial sunlight has been observed in some individuals. Small amounts of drug and short exposure to these sources of sunlight may produce an exaggerated sunburn reaction which may range from erythema over the exposed parts of the body to severe skin manifestations. In a smaller proportion, photoallergic reactions to this drug, as well as other tetracycline derivatives, have also been reported.

Such patients should be warned to avoid direct exposure to natural or artificial sunlight while under treatment and to discontinue the drug at the first evidence of skin discomfort.

Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

PRECAUTIONS AND SIDE EFFECTS: The use of antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans. However, use of demethylchlortetracycline during tooth development (= last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (=yellow-grey-brownish). This effect occurs mostly during long-term use of the drug but it has also been observed in usual short treatment courses.

As with all other antibiotics, side reactions which might be encountered include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Rare cases of anaphylactoid reactions have been reported following demethylchlortetracycline. Appropriate precaution is advised.

With full therapeutic doses in infants, increased cranial pressure with bulging fontanels has been observed. The frequency has been rare and all signs and symptoms have disappeared rapidly upon cessation of treatment.

ADMINISTRATION AND DOSAGE: *ADULT:* The average daily adult dosage is 4 divided doses of 150 mg. each or 2 divided doses of 300 mg. each.

An initial dose of 300 mg. may be used in the more severe infections but a single dose exceeding 300 mg. is thought to be unnecessary.

INFANTS AND CHILDREN: The dosage is 3 to 6 mg. per pound body weight per day or 6 to 12 mg. per Kg. per day, divided into 2 or 4 doses dependent upon the severity of the disease. This should not be given with milk formula or other calcium containing foods and should be given at least one hour prior to feeding.

Because of the cumulative effect in the body, continuation of high doses beyond the first few days is thought to be unnecessary.

Therapy should be continued beyond the time when characteristic symptoms or fever have subsided; however, DECLOMYCIN Demethylchlortetracycline, because of its unique property of prolonged stability in body fluids, permits serum activity for 24 to 48 hours after the last dose. The incidence of rheumatic fever or glomerulonephritis following streptococcal infections suggests that therapy of a streptococcal infection should be continued for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 1 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.[4,5,6]

In the treatment of pustular acne vulgaris an initial dose of 600 mg. daily for one or two weeks may, in most cases, be reduced to 300 mg. or 150 mg. daily for remainder of treatment course.[7]

Absorption is impaired by the concomitant administration of high calcium content drugs such as some antacid medications, foods and some dairy products such as milk. Oral forms of demethylchlortetracycline should be given 1 hour before or 2 hours after meals.

REFERENCES

1. Kunin, C. M.; Rees, S. B.; Merrill, J. P. and Finland, M.: Persistence of Antibiotics in Blood of Patients with Acute Renal Failure. 1. Tetracycline and Chlortetracycline, *J. Clin. Invest. 38*(9):1487-1519 (Sept.) 19
2. Kunin, C. M. and Finland, M.: Restrictions Imposed on Antibiotic Therapy by Renal Failure, *Arch. Int. Med. 104*(6):1030-1050 (Dec.) 19
3. Dowling, H. F. and Lepper, M. H.: Hepatic Reactions to Tetracyclin *JAMA 188*(3):307-309 (April 20) 1964. 4. Kingston, J. R.; Chanock, R. Mufson, M. A.; Hellman, L. P.; James, W. D.; Fox, H. H.; Manko, M. A. a Boyers, J.: Eaton Agent Pneumonia, *JAMA 176*:118-123 (April 15) 19
5. Mufson, M. A.; Manko, M. A.; Kingston, J. R. and Chanock, R. Eaton Agent Pneumonia—Clinical Features, *JAMA 178*:369-374 (Octo 28) 1961. 6. Editors: Eaton Agent Pneumonia, *JAMA 178*:414-415 (tober 28) 1961. 7. Kanof, N. B. and Blau, S.: Oral Demethylchlorte cycline in the Treatment of Pustular Dermatoses, *Antibiotics Ann* 1959-1960. D48—4/65

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Isoniazid Prophylaxis in General Practice

GEORGE W. COMSTOCK, MD
Associate Professor of Epidemiology, The Johns Hopkins University

THE USE OF ISONIAZID to prevent tuberculosis is now well founded, largely as the result of large scale controlled trials conducted by the United States Public Health Service together with many cooperating institutions throughout the country. Begun in 1955, these trials have included nearly 70,000 persons who represent all ages, many races, and a wide range of tuberculosis exposure and risk.[1-5] Although there are still questions to be answered, there is also sufficient knowledge to indicate a number of situations where isoniazid ought to be used prophylactically. These situations offer the general practitioner an opportunity to be more active in the control of tuberculosis than has been possible heretofore.

RATIONALE

Available evidence suggests that isoniazid is effective through its action as an antibiotic. It prevents inapparent tuberculosis from becoming manifestly active by its action on living tubercle bacilli. If no tubercle bacilli are in the body when isoniazid is taken, no effect can be expected. Basically, then, isoniazid prophylaxis is treatment of tuberculosis which is active but not sufficiently so to be detected by present methods.

When it is possible to demonstrate activity in a tuberculosis lesion, large numbers of organisms are present, and with increasing numbers of bacilli, the likelihood of naturally occurring isoniazid-resistant mutants also increases. If there are sufficient numbers of resistant mutants, single drug therapy may fail to halt the disease process. For this and other reasons, demonstrable active tuberculosis is best treated by a combination of effective drugs.

Supported by Public Health Service Research Career Award No. 1-K6-HE-21 from the National Heart Institute.

With no evidence of active tuberculosis, it is safe to use isoniazid alone because the total number of organisms is likely to be sufficiently low that the normal defense mechanisms of the body can handle the few resistant ones. Adding another drug to isoniazid increases the cost of prophylaxis and reduces its acceptability to the point where it is no longer feasible. Nor is there evidence that better results are obtained by the use of two or more drugs in the absence of demonstrably active disease.

DOSAGE

Isoniazid is given orally in doses approximating 5 mgm/kg body weight, the usual daily dose of 50, 100, 200 or 300 mgm being given once each day. Young children can tolerate larger doses per kg of body weight, but there is no direct evidence that increasing the dose to 10 or 50 mgm/kg does either good or harm. For adults, larger doses increases the risk of peripheral neuritis. The durration of treatment has not been adequately studied. Almost all studies have continued medication for one year. In one trial, giving isoniazid for two years did not improve the results.[6]

SIDE EFFECTS AND CONTRAINDICATIONS

Isoniazid in the usual dosage is remarkably nontoxic with infrequent side effects.[7, 8] Nausea, dizziness, and skin rashes occurred occasionally in the Public Health Service cooperative trials. Peripheral neuritis, sometimes encountered in the treatment of tuberculosis, was notable by its absence in this large series.

Because isoniazid is a convulsant drug in toxic

doses, it is understandable that its use in the presence of epilepsy has been tempered with caution. However, in a sizable experience with epileptics, the only important side effect was somnolence among patients on anticonvu'sant therapy. There was no increase in the frequency of convulsive seizures.[9]

As with all potent drugs, isoniazid should be stored out of reach of small children.

INDICATIONS

Taking medication daily for a year is not a simple thing to accomplish. Achieving a reasonable approximation to perfection (70 to 90%) requires a significant amount of supervision and encouragement. This ingredient of isoniazid prophylaxis accounts for the major portion of its cost, for isoniazid itself is an inexpensive drug. It would seem wise for the physician to require that the person taking prophylaxis, or a responsible member of the family, be seen at least once a month for renewal of the prescription for isoniazid. Periodic visits give a chance to ascertain the regularity with which medication is taken, to suggest methods for improvement when necessary, and to check on possible side effects.

Another consideration in the use of isoniazid prophylaxis is its duration of effect. During the year of medication, isoniazid caused a 70 to 80% reduction in the incidence of tuberculosis. In subsequent years, the reduction has been less marked but has remained at about 50% for a period of six to eight years with no indication yet of a further decrease in effectiveness.[10, 11]

Taking all presently known factors into account, isoniazid prophylaxis seems indicated primarily for infected persons who have a significant chance of harboring active tubercle bacilli:

1. Persons with x-ray evidence of pulmonary tuberculosis (other than calcification only) but without evidence of active disease.
2. Persons likely to have been recently infected, who include three important subgroups.

a) *Recent converters*—Both words in this term need definition. In this connection, I would consider two to three years as recent, and a converter as a person whose induration to 5 TU (0.0001 mgm) of PPD increased from less than 10 mm to 10 or more mm, *and* at the same time increased by at least 6 mm. Less marked increases in tuberculin sensitivity are unlikely to represent tuberculous infections in Maryland. For persons with a positive Tine or Heaf test after a previously negative test, I would define as converters only those whose positive reactions to the multiple puncture tests are confirmed by induration of 10 or more mm to 5 TU of PPD. False positive Tine or Heaf tests appear to be fairly common among Maryland school children.[12]

b) *Household associates of active cases*—These persons have a high risk of developing tuberculosis, especia'ly during the year or two after exposure. A large proportion of contacts are infected by the time the case is diagnosed; others may develop evidence of infection within the next few months. Consequently, members of the exposed household should be kept under periodic surveillance for some time. The addition of daily isoniazid for one year to the program of contact follow-up requires little effort on the part of the supervising physician and greatly reduces the likelihood of new tuberculosis among the family.

There may be practical advantages to prescribing isoniazid for all members of the household regard'ess of their initial tuberculin status. A person who is negative at the initial test may be in the pre-allergic phase of infection, a time when isoniazid prophylaxis presumably should be highly effective. More importantly, medication prescribed for a family unit is less likely to be forgotten than that prescribed for an individual. If any member of the group remembers to take medication, the entire family will be reminded. The likelihood that all members will forget is obviously less than that for a single individual.

c) *Tuberculin reactors among school and preschool children*—As a result of increased interest in tuberculin testing programs, an appreciable number of children are being identified as positive reactors to tuberculin. In most instances, the primary purpose of these programs is to trace the sources of infection. However, having identified a child as a reactor, it seems wise to expend a little more effort and add protection against the possible consequences of this infection. If the child reactor was identified by means of the Tine of Heaf test, the tuberculin test should be repeated using 5 TU of PPD. Only those with 10 or more mm of induration to this dose should be given prophylaxis, because young persons from this area with smaller reactions are not likely to have been infected with tubercle bacil'i.[13]

Very young children who react to tuberculin are also *ipso facto* recent converters. Although both the probability of recent infection and the risk of subsequent disease both diminish with age, the fact that isoniazid prophylaxis appears to result in long-term protection makes its use reasonable for children identified as reactors in programs initiated for other purposes. While isoniazid prophylaxis does not yet constitute a valid reason for tuberculin testing school populations, its use should add significantly to the benefits of such a program.

Tuberculin testing as a routine part of the preschool checkup and the increasing popularity of school tuberculin testing programs will bring more and more child reactors to the attention of practicing physicians. After a careful examination has ruled out the presence of active tuberculosis, and the rest of the family has been checked for possible sources of infection, the physician can make a positive contribution to the future health of the child and to public health by recommending and carefully supervising a program of isoniazid prophylaxis.

REFERENCES

1. Mount, F.W., and Ferebee, S.H.: Preventive effects of isoniazid in the treatment of primary tuberculosis in children, *New Eng J Med,* 265:713, 1961.
2. Ferebee, S.H., and Mount, F.W.: Tuberculosis morbidity in a controlled trial of the prophylactic use of isoniazid among household contacts, *Amer Rev Resp Dis,* 85:490, 1962.
3. Mount, F.W., and Ferebee, S.H.: The effect of isoniazid prophylaxis on tuberculosis morbidity among household contacts of previously known cases of tuberculosis, *Amer Rev Resp Dis,* 85:821, 1962.
4. Comstock, G.W.: Isoniazid prophylaxis in an undeveloped area, *Amer Rev Resp Dis,* 86:810, 1962.
5. Ferebee, S.H., et al.: A controlled trial of isoniazid prophylaxis in mental institutions, *Amer Rev Resp Dis,* 88:161, 1963.
6. Katz, J., et al.: Effect of isoniazid upon the reactivation of inactive tuberculosis, *Amer Rev Resp Dis,* 86:8, 1962.
7. Groth-Petersen, E.; Gad, U.; and Ostergaard, F.: Mass chemoprophylaxis in Greenland, *Amer Rev Resp Dis,* 81:643, 1960.
8. Ferebee, S.H.; Mount, F.W.; and Comstock, G.W.: The use of chemotherapy as a prophylactic measure in tuberculosis, *Ann NY Acad Sci,* 106:151, 1963.
9. Murray, F.J.: Outbreak of unexpected reactions among epileptics taking isoniazid, *Amer Rev Resp Dis,* 86:729, 1962.
10. Ferebee, S.H.: United States Public Health Service trials of isoniazid prophylaxis, Excerpta Medica International Congress Series, 69:108, 1963.
11. Arctic Health Research Center, U. S. Public Health Service, Anchorage, Alaska: Unpublished data.
12. Dettor, V.B.: Unpublished data.
13. Sartwell, P.E., and Dyke, L.M.: Comparative sensitivity of college students to tuberculins PPD-S and PPD-B, *Amer J Hyg,* 71:204, 1960.

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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 4: Rupture of Uterus

The patient was a 33-year-old multipara with two previous normal full-term deliveries. She went into labor spontaneously three days past term on April 15. After an uneventful labor of five hours, she was taken to the delivery room, where examination revealed the fetus to be in the ROP position. The head was manually rotated to the direct OA position, and outlet forceps were applied. Considerable traction was necessary to deliver the head, but even more difficulty was encountered with the delivery of the shoulders.

The child was a normal living male, weighing 8 lb 5 oz, who breathed promptly immediately after delivery. Vaginal bleeding was minimal, with the total being estimated at about 200 cc. A midline episiotomy had been performed and was repaired. The cervix was examined and no lacerations noted, and at this stage there was no unusual bleeding. Blood pressure was stable at 110/70 during delivery and at perineal repair.

Thirty minutes after delivery the patient was taken from the delivery table; the blood pressure was still 110/70. The uterus was firm, bleeding was minimal, and the patient was beginning to awaken from her general anesthetic of ethylene and oxygen.

Suddenly the patient gasped deeply several times and became intensely cyanotic. The uterus was still quite firm and there was no external vaginal bleeding. The impression at this point was that the patient had probably had a pulmonary embolus or coronary occlusion. Her blood pressure was now unobtainable. She was given vasoconstrictors and stimulants. In spite of all measures, including open chest cardiac massage, the patient was pronounced dead approximately two hours postpartum.

Autopsy revealed a 10 cm laceration in the left side of the lower uterine segment. The peritoneal cavity contained 1300 cc of blood.

COMMENT

The committee members reviewed this case history with considerable interest and not a small amount of sympathy for the attending physicians. On the basis of the committee's overall philosophy that preventability is based upon whether or not *ideal* care had been given, this was voted as a preventable maternal death. The major point of criticism in the management of this case centers upon the fact that shoulder dystocia is a notorious cause of rupture of the lower uterine segment. In addition to inspection of the cervix for lacerations, had the uterine cavity been explored, the rent in the uterine wall could have been detected and prompt hysterectomy would almost certainly have saved this patient's life.



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Resolution*

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Whereas, emotional problems comprise the largest single group of health problems in schools, and

Whereas, such problems are frequently multiple in origin as well as in manifestation, and

Whereas, many persons of varied training and experience are needed to deal with these problems, and

Whereas, the medical aspects of such problems must not be overlooked, therefore be it

Resolved that schools establish policies and protocol to insure that each member of the team—such as teachers, psychiatrists, guidance personnel, psychologists, social workers, and physicians—function according to his ability and qualification, and that medical consultation always be available and utilized in the approach to these problems, and be it further

Resolved that personnel responsible for guidance have adequate preparation in the area of health.

STATEMENTS*

Wed and Unwed Parents.—The Joint Committee on Health Problems in Education, recognizing that preventive measures for the problem of early and unwanted pregnancies will be slow in effecting results, re-emphasizes its statement of 1963 urging local schools and communities to devise a plan for the continued education for married students and unwed parents.

Hypnosis as Entertainment in Schools.—In accordance with the statement of the Council on Mental Health of the American Medical Association, the Joint Committee on Health Problems in Education recognizes that hypnosis has been placed in the framework of psychiatry and psychodynamic psychology. The Council on Mental Health warns that even under controlled medical conditions hypnosis is hazardous.

Therefore, the Joint Committee cautions schools and colleges against using hypnosis as a form of entertainment and recommends further that students should be discouraged from practicing hypnosis.

*Adopted by Joint Committee on Health Problems in Education, National Education Association and American Medical Association, March 28-30, 1965.

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MENTAL HANDICAPS AND LANGUAGE DISORDERS

HENRY J. MARK, ScD
Associate Professor of Pediatrics Otolaryngology, and Environmental Medicine, The Johns Hopkins Hospital

In the normal, as well as in the mentally handicapped child, a realistic understanding of the child's intellectual capabilities is a key to educational success and good mental health for the child and his family. In the child with a suspected handicap, a quantitative analysis of the areas containing successes and failures achieved on objectively scorable psychometric-type language, performance, and academic achievement tests can provide excellent descriptions of patterns of relative mental strength and weakness. Especially for the handicapped child, properly selected statistical techniques can provide good predictors of learning and vocational success in many areas and guard against the likelihood of establishing goals which are either too high or too low for the patient.

Failure to select the appropriate quantitative or statistical methods often results in poor patient and family management. The commonest types of errors are: 1) preselection of an average-type IQ statistic for describing a child whose mental abilities are too variable to be represented by a single average-type figure, and 2) ignoring the quantitative features of variable score distributions, including ignoring of diagnostic success and failure patterns which are often embedded in such distributions. Children with language disorders provide us with countless examples of suboptimal patient and family management when these two types of errors are made.

PENALTIES FOR PRESELECTING STATISTICS

An examiner trained to administer formal IQ tests to "normal" persons is often overly motivated to conform closely to the prescribed data analysis techniques required by "the manual." He must, therefore, be sensitive to the error of preselecting an average-type statistic to represent the mental skills of the handicapped child with an excessively variable score distribution.

As an example, we can cite a child who achieves an IQ equivalent (IQE) score of 80 on performance tests, (eg, block design tests) which correlate highly with full-scale intelligence, and an IQE of 50 on language tests (eg, vocabulary or comprehension tests) which also correlate highly with full-scale intelligence. The serious error of "averaging" these scores and representing such a distribution by an IQ of 65 must be avoided. It would nearly always be a mistake to advise the family to raise the child as though he had an IQ of 65. His skills are either considerably better or considerably worse than that.

If the child suffers from a central rather than a peripheral auditory or language disorder, the chances of making such an error are vastly increased. For example, a four-year-old with a total or partial auditory agnosia may well show such a score distribution. He is clearly not deaf, as evidenced by his excellent hearing sensitivity. He may have no sound resolution difficulty as evidenced by his ability to mimic or parrot speech patterns such as words, phrases, or sentences. Yet, with an auditory agnosia, he may have no ability to remember the meaning of any sound whatsoever. In such a child, the auditory development may appear normal up to the age where

memory for sounds is expected. After that age, all further auditory development may cease and already developed "alerting" and "orienting" skills may drop out (perhaps because the auditory modality, relative to the visual modality, provides little useful information to the child).

In such a child, we must analyze the distribution of scores to determine what descriptive statistics to use. First we compute an intrapatient standard (in this example, IQE=80). This is a maximum-type statistic based on one or more of the tests which ordinarily correlate highly with full-scale intelligence. Second, we establish some cutting value (CV) for singling out areas which are significantly below the intrapatient standard and which may contain special handicaps. In our example, the language functions would be "significantly low,"—less than .8 of intrapatient standard (a useful CV). Third, we must pursue a detailed examination which is sensitive and specific for the special handicaps embedded in the "suspicious" low areas. Unless we follow such procedures systematically, we could not detect the auditory agnosia in this child and are at high risk of confusing him with an evenly defective child with an IQ of 65. A child with a 65 IQ would be viewed as more severely defective but with no special language problems.

In contrast, our child with the intrapatient standard at the 80 IQE level and the auditory agnosia might be exposed to the same educational program as other deaf children with comparable intrapatient standards. Unless we specify a program geared to this higher IQ level, we will not exploit the child's true capabilities.

Thus, in the example cited, a formal IQ would be unrealistically low. Other children with auditory agnosia may, in addition, be more severely defective; it is quite common for such children to possess uncanny parroting abilities in spite of the fact that all other mental skills, including performance skills, fall into the more severely defective range. In young children, these pseudolinguistic abilities often yield formal IQ scores which are excessively high. A program aimed too high will be a constant source of emotional stress for the patient and the family.

The fact that the formal IQ may be unrealistic (too low or too high) in many handicapped children unfortunately has led many clinicians to abandon altogether the IQ-type concept for such children. Let us, therefore, see what penalties are associated with abandoning more formal quantitative procedures and relying heavily on intuitive judgment.

PENALTIES FOR FAILURE TO IDENTIFY AREAS OF STRENGTH AND WEAKNESS AND DETECT EMBEDDED HANDICAPS

Again, let us use the example of the four-year-old who achieves a performance scale IQ of around 80 and language scale IQ of no better than 50. All too often the low scores are ignored, and parents will be reassured by well-meaning professionals that the child will catch up in the language area: they may be told that he just doesn't have the need to express himself; it may be suggested that he is just emotionally immature and shy, and everything will be all right; or the family may be advised to seek psychiatric help for the entire family because autism or childhood schizophrenia may lurk in the background. All of these etiologic hypotheses are frequently advanced by examiners who have not collected systematic mental measurements and have not analyzed the distribution of test scores for significant success and failure patterns. According to our experience, in less than one out of 1,000 cases of handicapped children seen, will we suspect such causes *after* we have systematically analyzed the child's mental skill distribution. The overwhelming chances are that the low scores hide one or more of a large number of identifiable modality-specific disorders.

Some of these modality-specific disorders are disorders of sensitivity and resolution more easily remedied when detected early in life; for others, remedies can be applied at any time. Still others are not known to yield to any specific therapy, but we suspect that some therapy is better than none.

The various types of auditory memory difficulties, including the auditory agnosias, are examples of conditions for which no specific therapies are known to be efficacious; yet it would be a serious mistake to think that correct diagnosis is not important. The absence of scientific data to prove the efficacy of specific procedures does not preclude their usefulness in some cases. It does mean, however, that we have no right to hold out unrealistic expectation levels to the patients, the therapists, or the families.

Even if we knew that no therapy were effica-

cious for a given case, the need for accurate diagnosis is basic for the mental health of the child and his family. The very suggestion that an emotional disorder or interpersonal family relationships may be etiologically related to such a severe mental handicap as a language disorder constitutes a tremendous challenge to the family. Whatever euphemism we select for conveying these possibilities to the family, they will invariably feel "responsible." Most families will then reason that if they caused the damage they can undo it. In view of the generally poor prognosis associated with these specific handicaps, even the most disciplined family efforts at reorganizing life patterns are likely to go unrewarded. By the time the families realize the true nature of the handicaps, they have often been through prolonged periods (years) of extreme emotional stress and quite often have acquired a profound distrust of all professional advice. In many cases, opportunities to educate the child through collateral channels will have been unnecessarily delayed.

SUMMARY

Patients with language disorders have taught us one important lesson. The diagnostic examination of any patient with a suspected mental handicap is not complete until he has received a systematic survey of important areas of intellectual functions and until the quantitative measurements have been analyzed systematically by actuarial techniques capable of revealing the large number of handicaps which may be embedded in such a distribution of test scores.

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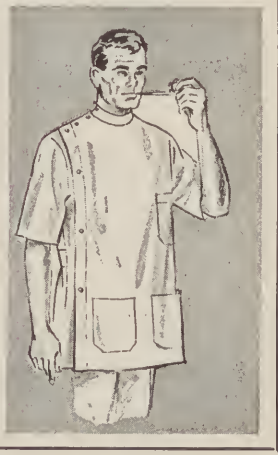


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The need for continuing dental care during pregnancy has long been recognized. Oral infection and related ills, unless properly treated, can seriously impair the health of mother or baby or cause complications during the period of pregnancy. Now every prenatal patient registered at the Baltimore Maternity Center will receive a complete dental examination, including radiographs as required for diagnosis.

Follow-up dental care will include 1) eliminating infection by treatment of gums and removal of infected teeth or other sources of infection, 2) cleaning the teeth and counseling in self-care, 3) restoring decayed teeth, 4) adjusting abnormal bite for improved function, and 5) providing dentures as may be necessary for unusual conditions.

Dr. Palmer was born in Baltimore. He is a graduate of Baltimore City College, the University of Maryland, and the Baltimore College of Dental Surgery. Before entering the University, Dr. Palmer served for four years in the U.S. Air Force, both in this country and in Korea. After graduation from the dental school in 1961, he served as clinical instructor in oral diagnosis and in prosthetic dentistry at the school and as a clinic dentist for the Baltimore City Health Department.

The facilities of the Baltimore Maternity Center are available to any needy expectant mother. The hours of registration are 8:30 AM to 2 PM, Monday through Friday.

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Physicians may refer medically indigent patients to the Center for registration and care. Further information regarding this service may be obtained by calling 752-7282.

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
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Highlights

ENCEPHALITIS

THERE ARE THREE TYPES of mosquito-borne encephalitis in the United States. These are Eastern and St. Louis, which have been responsible for cases in the eastern part of the country, and Western, which has been largely confined to central and western zones. Although reports of human cases in Maryland have been rare—there were none in 1964—there is a possibility that the disease may not always be recognized.

The Division of Epidemiology is requesting physicians and hospitals in areas where mosquito-borne encephalitis seems most likely to occur to be on the alert for any of the three types of infection in all cases of encephalitis which come to their attention.

An extensive outbreak of St. Louis encephalitis occurred in southern New Jersey and eastern Pennsylvania last year. Migratory and permanent resident birds were found to be carriers of the virus. Although no cases were reported in Maryland, it is likely that there are infected birds here, and human cases may be anticipated.

There is no difference in the clinical picture of Eastern and St. Louis encephalitis. In recent outbreaks there has been a preponderance of cases among elderly people. The onset is often sudden, with fever, stiff neck and back, convulsions in children, and coma. There is no specific treatment.

In times of outbreak, mosquito eradication and avoidance of mosquito bites are the only methods of control.

LABORATORY TESTS FOR RUBELLA

Recent national publicity on the various laboratory procedures dealing with the management of rubella during pregnancy calls for some clarification. It is pointed out that when contracted early in pregnancy rubella is likey to cause disastrous deformities in the fetus. Immunization against rubella is still in the phase of research laboratory development. The principal prophylactic measures currently available are either the administration of gamma globulin (its value in protecting the fetus has not been established) or the induction of therapeutic abortion.

Serologic tests to identify the presence of antibodies by the neutralization or by the fluorescent techniques are time consuming and expensive, not yet widely practical. A test for complement-fixing antibody which can be completed in 24 hours has recently been developed. This antibody rises during an actual infection but has a relatively short period of persistence. Its presence indicates a protective immunity but, if negative, this test alone gives no early guidance for the prophylactic management of a woman exposed to rubella during early pregnancy. Furthermore, the materials for this new test are as yet available only in limited amounts. Despite the limitations, the Bureau of Laboratories is presently offering the three serologic tests to assist physicians requesting this service in the management of rubella during pregnancy.

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FOOD POISONING EPISODE

Reports of food poisoning after seven parties which were held on the same day in the Washington metropolitan area were received by the District of Columbia Health Department. Four of these parties were in Montgomery County and one in Prince George's; all had been catered by a Washington establishment. The characteristics of the episode were those of a Salmonella infection. Approximately 50% of the guests at these parties became ill. After a meeting in Washington of the epidemiologists and representatives of health officers of the metropolitan area, which the Department's epidemiologist attended, the Maryland outbreaks were investigated by members of the Montgomery and Prince George's County Health Departments and a representative of the Division of Epidemiology. Almost all the foods which were served were found to be contaminated. The organism was identified as *S. meleagridis*. There have been no reports of secondary cases among the infected families in Maryland.

STATE OF MARYLAND

Department of Mental Hygiene

THE HOSPITALIZED NARCOTIC ADDICT

A RECORD 184 PATIENTS with a primary diagnosis of narcotic addiction were admitted to Maryland psychiatric hospitals last year. This growing number reflects the continuing development of this specialized treatment program. As an integral part of this program, the Department's Research Division, in conjunction with the Department of Parole and Probation, this year opened a narcotic clinic which has thus far accepted 37 patients.

Although these 184 came from all segments of the state's population, the majority were characterized by the following:

1. Half were between the ages of 25 and 34, and an additional 30% were younger.
2. Two out of every three had at least some high school education.
3. Nearly 90% were Baltimore City residents; the others were from eight counties.
4. Sixty per cent were Negro males and 20 per cent were white males.
5. Forty per cent were single and an equal number were married.
6. For more than three fourths this was the first hospitalization in a psychiatric facility.

Addiction to narcotics is a disease which in most cases can be traced to the bitterness and frustration of the culturally and economically deprived masses who crowd the inner core areas of our metropolitan centers. As with alcoholics, successful treatment is difficult since it requires complete withdrawal, the motivation necessary for continued abstinence, the development of constructive influences, and the resolution of the underlying factors related to the problem. In the United States the best known treatment facility is the federal hospital at Lexington, Ky. It has reported that only a small proportion of its former patients manage to abstain from drugs for any length of time.

Accurate statistics are not available regarding the extent and variety of narcotic addiction in the general population and the course of the illness. Addicts are believed to be heavily concentrated in the slum areas of major seaports, where narcotics are most readily available. Research is hampered by the difficulty of obtaining accurate data, since such information might be used as evidence in criminal proceedings against users and suppliers of narcotics. In Maryland this type of research data is legally protected against court subpoena. It would therefore be possible to carry out these studies as part of the Psychiatric Case Register program.

Ultimate success in minimizing the number of addicts depends on a twofold program for the prevention of new cases and the treatment of present users. The former depends on continuing efforts to reduce the illegal supply of narcotics and on the elimination of factors responsible for the initial adoption of the use of narcotics. The latter requires the development of a closely coordinated program involving public and private agencies as well as organized groups of former users such as Addicts Anonymous and Synanon.

Kurt Gorwitz

Maryland Nurses Association

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Statement on Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice Act

A MAJOR CONCERN OF NURSES and of the professional nursing organization is related to the professional and legal scope of their practice in the administration of medications and treatments prescribed by a licensed physician or dentist (the dependent area of nursing function).

The American Nurses' Association has encouraged liaison activities between state nurses associations and state medical societies to study problems occurring within the dependent area of nursing function in order to arrive at joint policy statements on any procedures under question. The American Medical Association has encouraged such liaison activities. In June, 1965, a Nursing Liaison Subcommittee of the Liaison Committee of the Medical and Chirurgical Faculty of the State of Maryland became formal.

The Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice Act, which appears on page 32 of this *Journal*, is the outgrowth of a survey of practices within the dependent area of nursing function conducted by an Ad Hoc Committee of the Maryland Nurses Association and the Hospital Council of Maryland in conjunction with the Maryland Nurses Association Committee on Professional Nursing Practice in 1964. This brief report, of course, does not cover all areas of dependent function in nursing.

The Maryland Nurses Association views the report as constituting guidelines for further definition and policy development within individual institutions and agencies. It is implicit 1) that the registered nurse performing these acts shall have received formal theoretical instruction and supervised clinical practice and shall have demonstrated proficiency in performance satisfactory to the medical and nursing staffs; 2) that she act under *written* orders of a licensed physician or dentist; and 3) that she act under *written* policies established by medical, administrative, and nursing staffs.

Although the physician, hospital, or agency assumes responsibility for acts delegated to the nurse, she must always be aware that she is still responsible for her own acts.

Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice (see page 32) was adopted by the Executive Committee of the Board of Directors of the Maryland Nurses Association on July 23, 1965, with the addendum contained in this statement.

Professional Business Management

A New Feature

Practice Management for Maryland Physicians

GEORGE H. YEAGER, MD
Editor, Maryland State Medical Journal

PARTICIPANTS IN OUR RECENT readership survey indicated a need for information relating to practice management and ancillary activities. Consequently, this monthly column will be devoted to practice management, economics, and taxes, as they apply to medicine.

Mr. Wilburn L. McClure, Jr., a practice management consultant in Baltimore, will be your columnist. The editorial staff will work closely with Mr. McClure so that our readers may gain the valuable information which they desire.

To some, the field of practice management activities might appear to be new. You should know, however, that the first practice management firm working exclusively with physicians was begun in 1931. You might also be interested to know that the first issue of *Medical Economics* appeared in the fall of 1923.

An attempt will be made to relate the information in this series to the practice of medicine in Maryland. You must realize, of course, that much of the information must be general and would apply to a practice anywhere in the United States.

We solicit your comments, suggestions, and questions. From your letters your columnist will try to provide information based upon a consensus of desired information.



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Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

More About the Information Requirements of the Practicing Physician

DURING THE FINAL PERIOD of this workshop,* a design for the study of medical library use was presented by Susan Crawford, director of the Archive-Library Department of AMA. In response, medical executives and directors of medical libraries offered examples illustrating use patterns in their own libraries.

This meeting is the first of a three-stage program sponsored by the American Medical Association. The second stage will be an extensive study on patterns of medical library use to provide basic data for planning. The final stage will consist of discussing the findings and making recommendations.

A library exhibit is being planned for the semiannual meeting. We will try to comply with any special requests members might make, either for books or subjects. If you have any gripes, bring them along too! At least come by the exhibit and get acquainted.

MEDICAL LIBRARY ASSOCIATION CONVENTION, MAY 31–JUNE 4

The Medical Library Association, at its recent convention in Philadelphia, sponsored a course on new reference tools and their use. The Committee on Continuing Education selected five basic tools, common to many health sciences libraries: Biological Abstracts, Chemical Abstracts, Excerpta Medica, MEDLARS, and the Science Citation Index.

With the increasing use of mechanical means to store and retrieve information, libraries are benefiting by a number of byproducts. Various programs can be written for computers, thereby enabling input data to be recalled in a great many ways. The course clarified the composition and makeup of these tools so that they may be utilized more effectively. Recent changes in format were discussed as well as plans for the future.

The Medical Society group dinner meeting was one of the most interesting sessions of this national conference on medical librarianship. The overall subject was: Society Library Service—Values and Forecasts.

Edward C. Rosenow, Jr., MD, American College of Physicians, spoke on "The Value of the Library in the Administration of a Large Medical Society"; Fred B. Rogers, MD, on "The Value of the Library when the Patient is Ill"; and Alan M. Rees, Western Reserve School of Library Science, on "Assessing User Requirements."

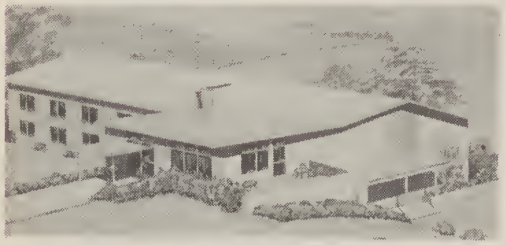
At the conclusion of this program, Miss Frances Bucy, Denver Medical Society, was elected chairman, and Elizabeth Sanford was elected secretary of this group for the coming year.

*See also the Library Page in the July, 1965, *Maryland State Medical Journal,* and the *AMA News,* June 7, 1965.

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RECENT ADDITIONS

American Public Health Association. *Diagnostic procedures and reagents; technics for the laboratory diagnosis and control of the communicable diseases.* 4th ed. 1963.

American universities and colleges. 9th ed. American Council on Education, 1964.

Bowers, Warner Fremont. *Techniques in medical communication.* Thomas, 1963.

Directory of medical specialists certified by American Boards. Vol. 12, 1965.

Ford Foundation grants in New York from 1937 to May 31, 1963. 1963.

Frenay, Mary Agnes Clare. *Understanding medical terminology.* 3rd ed. Catholic Hospital Association, 1964.

Gartland, John J. *Fundamentals of orthopaedics.* Saunders, 1965.

Goldberger, Joseph. *Goldberger on pellagra.* Louisiana State University Press, 1964.

Grace, William Joseph. *Practical clinical management of electrolyte disorders.* Appleton-Century-Crofts, 1960.

International Symposium on End Results of Cancer Therapy. Sandefjord, Norway, 1963. National Cancer Institute, 1964.

The Merck veterinary manual. Merck, 1961.

The National formulary. 11th ed., 1960.

Rosenman, Eugene. *An outline of pulmonary function and pulmonary emphysema.* Thomas, 1964.

Semmes, Raphael E. *Ruptures of the lumbar intervertebral disc, their mechanism, diagnosis, and treatment.* Thomas, 1964.

Stone, Harvey B. Collection of Dr. Stone's published writings from 1908-1963. 1965.

U. S. Federal Aviation Agency. List of aviation medical examiners. 1965.

Whittam, R. *Transport and diffusion in red blood cells.* Williams & Wilkins, 1964.

Year book of orthopedics and traumatic surgery. 1964/65.

Year book of pathology and clinical pathology. 1964/65.

Year book of urology. 1964/65.

Yoshida, Tomizo. *Ascites tumors: Yoshida sarcoma and ascited hepatoma (s).* National Cancer Institute, 1964.

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AUGUST, 1965 MRS. IRVING J. TAYLOR, *Auxiliary Editor*

1965 CONVENTION SUMMARY

THE SIXTEENTH ANNUAL CONVENTION of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland was held April 21 and 22 at the Holiday Inn. This was a departure from the usual practice of holding it at the Sheraton Belvedere Hotel. There were advantages and disadvantages in this move, which will be carefully evaluated.

The newspaper strike prevented our publicizing this as well as we had intended, but we were fortunate in having one article printed and the pictures of our two guest speakers, Mrs. William H. Evans, National President, and Dr. Ever Curtis, of the AMA Speakers Bureau.

The past presidents' breakfast was the first event of the busy two-day meetings. This was held at the Sheraton Belvedere Hotel with members and guests of the Faculty. In this way we were able to hear the inspiring talk by Dr. Annis. Leis were presented to each past president by Mrs. Baybutt, the outgoing president, and toasts were given by the members.

The general session and business meeting Thursday morning was well attended. Mrs. William Evans gave an interesting talk about the affairs of the Woman's Auxiliary to the American Medical Association. Mrs. Evans is a charming and dynamic speaker whose talk will be printed elsewhere for all who were not present to enjoy.

Mrs. Evans installed the new officers: Mrs. Martin E. Strobel, president; Mrs. Archie R. Cohen, president-elect; Mrs. Raymond L. Markley, secretary; Mrs. DeWitt E. DeLawter, recording secretary; and Mrs. George S. Malouf, treasurer.

Reports of all the chairmen were distributed in folders to everyone who attended. These reports tell the story of a busy and progressive year for our Auxiliary.

A social hour was held between the morning meeting and the annual luncheon. An impressive display of Auxiliary projects was arranged on tables surrounding the luncheon room. These depicted Doctors Day, safety, fund raising, and other activities. Mrs. Hirschfeld is to be congratulated on her work.

At the luncheon A. E. Goldstein, MD, praised the Auxiliary for its cooperation and good work in its projects. It was encouraging to the ladies to know they are wanted and really appreciated—including their spring hats.

Dr. Ever Curtis made the feature address. She echoed Dr. Annis' statements and brought home to us more forcefully the dangerous activities of those who follow communism. We felt quite serious and sober at the conclusion of her remarks.

Mrs. John E. Baybutt made a short talk on her year as president and then presented the president's pin to Mrs. Martin E. Strobel. Mrs. Strobel gave a short acceptance speech and a promise to give her best to this year for accomplishment and progress.

Mrs. Walter Hammett presented the past president's pin to Mrs. Baybutt and thanked her for her year of service and her loyal support of all activities.

It seems that as each year goes by we grow larger and accomplish more. The knowledge of our husbands' profession, its lighter moments and its areas of difficulty, are understood, and the effort

we give to further the advancement of medicine in the United States is well spent. The money raised and presented to AMAERF is but one phase of our efforts. Politically, we are informed and eager to help. It is well to belong to the great family of medicine, to participate in its problems and its rare light moments while working side by side.

Virginia H. Shipley



Mrs. James L. Johnson—

President, Woman's Auxiliary to the Cecil County Medical Society

MRS. JOHNSON WAS BORN in Tarrytown, N. Y. She majored in business. While working for the Federal Public Housing Authority she met her husband.

Active in Cecil County affairs, she is vice president of the YWCA, is on the board of directors of the Cecil County Community Chest, is chairman of the Youth Red Cross, is on the board of the Cecil County Red Cross chapter, is a member of the Maryland Council of Churches and the Union Hospital Auxiliary. Her hobbies are painting and golf.

Before becoming president of the Cecil County Auxiliary, Mrs. Johnson was mental health chairman and publicity chairman.

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BUSINESS MANAGEMENT OF A MEDICAL PRACTICE. Bernard D. Hirsh, LL B. Saint Louis: The C. V. Mosby Co., 1964. $7.75.

The author has been associated with the Law Department of the AMA for 10 years and is thus eminently qualified to counsel physicians in ways to avoid some of the common pitfalls in the business management of medical practice. A substantial part of the book is devoted to various model contracts which the physician is likely to require.

Legal language has been avoided as much as possible. While useful in forming a basis for informative communication between physician and attorney, this book in no way purports to be a do-it-yourself guide for physicians. To attempt to draft his own business contracts, the author says, would put the physician in "the same ridiculous position that a lawer might be in if he attempted surgery upon some member of his family with the aid of a text book."

THE LIVER AND PORTAL HYPERTENSION. Charles G. Child, 3rd, MD. Philadelphia: W. B. Saunders Co., 1964. $8.50.

This is Volume I in a series "Major Problems in Clinical Surgery," designed to bring to the practicing surgeon an up-to-the-minute report of the basic concepts and technical approaches to important and controversial surgical diseases and injuries. This volume is a classic account of portal hypertension which will provide an immediate practical guide to treatment.

REPORT OF THE COMMISSION ON THE COST OF MEDICAL CARE, vol I. Chicago: American Medical Association, 1964. $4.

The four volumes of this report are the findings of a three and a half year study on the cost of medical care. Volume I, the general report, covers such topics as "The Economics of Medical Care," "Medical Care Price Index," "Demand for Medical Care," and "Solo and Group Practice." It also contains summaries of the projects described in the other three volumes.

Volumes II, III, and IV cover "Professional Review Mechanisms," "Significant Medical Advances," and "Changing Patterns of Hospital Care," respectively.

REPORT OF THE COMMISSION ON DRUG SAFETY. L. T. Coggeshall, MD, Chairman. 1964.

The Commission on Drug Safety was founded by the Pharmaceutical Manufacturers Association in 1962 with a twofold charge: to explore in depth the myriad aspects of drug safety and to offer constructive recommendations. The objective of its efforts is "to provide maximum assurance to the public of safety of new drugs without imposing unnecessary delay in bringing the dramatic fruits of research to the public."

The drug-safety field was divided into 17 areas, and subcommittees of authorities in each of these areas were appointed. The reports of these subcommittees are included in this volume.

The Commission itself met monthly, and its full report is a major section of this volume.

Since the Commission on Drug Safety terminated its activities in 1964, after publication of its report, orders should be addressed to: *Federation of American Societies for Experimental Biology 9650 Wisconsin Avenue, NW, Washington, D. C. 20014.*

RESPIRATORY FUNCTION IN DISEASE, by David V. Bates, MD, and Ronald V. Christie, MD, Saunders, 1964. $15.50

Intended for practitioners and teachers who are not concerned with the highly technical aspects of respiration, this volume offers a working knowledge of the chemical and physiological facts about respiration and their clinical application.

PROCEEDINGS OF THE WORLD FORUM ON SYPHILIS AND OTHER TREPONEMATOSES, U.S. Department of Health, Education, and Welfare, 1964. $4

The World Forum on Syphilis and Other Treponematoses brought together 1,500 delegates from more than 50 nations, including many of the world's authorities on the treponematoses. The Proceedings include papers on the medical, administrative, and behavioral aspects of venereal disease control programs. They have been published with the hope that they will provide the guidelines for an aggressive, worldwide campaign against the treponemal diseases.

MEDICAL PRACTICE AND PSYCHIATRY: THE IMPACT OF CHANGING DEMANDS, Group for the Advancement of Psychiatry, Inc., 1964. 75¢.

This pamphlet is designed to aid physicians in meeting the increased demands from the public for help with the emotions of their patients. The report attempts to clarify the basis for some of the isolation and alienation that has occurred between psychiatrists and nonpsychiatric physicians and suggests some means for reducing the areas of difference.

Included in the pamphlet are chapters on the differing values competing for the physician's attention, aspects of the nature of mental illness, the nature of psychiatry and psychiatric practice, the mind-body dichotomy, the manpower storage, and the problems of sharing responsibility between psychiatrists and their nonpsychiatrist colleagues. The report also has sections on problems of communication related to referral and consultation and on the committee's hope that increasingly effective education for both psychiatrists and nonpsychiatrists will enable them to cooperate better meeting the changing needs of their patients.

INFECTIOUS DISEASES OF CHILDREN, ed 3, by Saul Krugman, MD, and Robert Ward, MD, Mosby, 1964. $15.75

New vaccines and recognition of new agents have brought dramatic changes in infectious diseases in the last four years. These new achievements are reflected in the third edition. The book is intended for pediatricians and others who deal with children and

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contains a concise description of certain common infectious diseases of children. It is not, however, an all-inclusive text on infectious diseases and omits many diseases with which the authors have had limited personal experience.

STEREOSCOPIC MANUAL OF THE OCULAR FUNDUS IN LOCAL AND SYSTEMIC DISEASE, by Frederick C. Blodi, MD, and Lee Allen, Mosby, 1964. $32.50

This book is an outgrowth of an exhibit shown at the AMA convention in June, 1963, and the American Academy of Ophthalmology and Otolaryngology in October, 1963. Accompanying this book is a collection of illustrative stereoscopic views of the fundus. A viewer is also included.

ALLERGY AND HYPERSENSITIVITY: A PROGRAMMED REVIEW FOR PHYSICIANS, ed 2 rev, Pfizer Laboratories, 1964.

This is the first of a series of programmed reviews conceived and produced jointly by Pfizer Laboratories and Basic Systems, Inc. The main body of the course focuses on concepts most widely accepted by authorities in the allergy field. The material is systematically organized in small, simple learning steps. It is not a substitute for more extensive reading and study.

SURGERY OF THE BREAST, by Louis H. Jorstad, MD, Mosby, 1964. $15

The author, a practicing surgeon, covers two major areas of this timely subject: what he has learned about chronic cystic disease and the surgical treatment of carcinoma of the mammary gland. Cases recorded are of his own patients.

SCINTILLATION SCANNING IN CLINICAL MEDICINE, edited by James L. Quinn, III, MD, Saunders, 1964. $11.50

The papers collected here were presented at the Symposium on Scintillation Scanning in Clinical Medicine, held January 30 and 31, 1964, at Winston-Salem, NC. Intended for physicians practicing nuclear medicine and for trainees in the field, this book affords a compact reference to current methods.

COMMON BACTERIAL INFECTIONS: PATHOPHYSIOLOGY AND CLINICAL MANAGEMENT, by Edwin J. Pulaski, Col MC USA, Saunders, 1964. $8.50

Antibiotics, rather than eliminating microbial diseases, as was once hoped, have instead caused the emergence of new infectious agents. It is more important than ever before that the physician understand the pathophysiology of the infectious process which forms the basis of accurate diagnosis and specific treatment. This text considers the dynamics of infection, current antimicrobial drugs, and clinical recognition, diagnostic aids, treatment, and prognosis of pyogenic infections in the various body system.

CURRENT PRACTICE IN ORTHOPAEDIC SURGERY, vol 2, edited by John P. Adams, MD, Mosby, 1964. $13.50

Following the format of the first volume, this volume continues the reviews and evaluation of current literature pertaining to orthopaedic surgery. The

contributors have further analyzed and interpreted the subjects and added comments of their own. Among the contributors is Raymond M. Curtis, MD, of Baltimore.

DISEASES OF METABOLISM. DETAILED METHODS OF DIAGNOSIS AND TREATMENT, ed 5. Edited by Garfield G. Duncan, MD. Philadelphia: W. B. Saunders Co., 1964. $28

As with the previous editions, this edition is intended to bridge the useful understanding between the investigator in the wide area of metabolism and the practitioner of medicine. Seven new chapters appear in this edition, and a number of new authors are represented. Some of the subject matter overlaps as several authors express their opinions on controversial topics.

CURRENT THERAPY 1965, edited by Howard F. Conn, MD, Saunders, 1965. $13

This is the seventeenth edition of an annual series designed to offer concise authoritative methods of treatment of those diseases the physician is most likely to encounter in private practice.

SIMPLE SPLINTING; The Use of Light Splints and Related Conservative Therapy in Joint Diseases, by Jerome Rotstein, MD, Saunders, 1965. $6.50

Corticosteroids have limited application in rheumatoid arthritis. Of greater value is a conservative therapeutic regimen consisting of rest and appropriate exercise of the inflamed joint. This book presents the techniques of immobilization that can be of help during limited periods in the treatment of rheumatoid arthritis.

SYNOPSIS OF CLINICAL TROPICAL MEDICINE, by Oscar Felsenfeld, MD, Mosby, 1965. $9.85

This synopsis summarizes the present status of clinical tropical medicine and correlates it with those findings in the basic sciences which are applicable to everyday practice. The four principal tropical diseases are tuberculosis, diarrhea, respiratory infection, and viral hepatitis. Diarrhea is discussed in greatest detail.

Leopold's PRINCIPLES AND METHODS OF PHYSICAL DIAGNOSIS, ed 3, by Henry U. Hopkins, MD, Saunders, 1965. $8.50

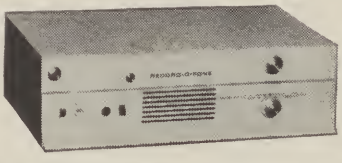
The primary purpose of this book is to provide an introduction to the basic procedures of history taking and the performance of a physical examination. An effort is made to help the student correlate the abnormal findings with the underlying physiologic or pathologic changes. Numerous changes have been made from the second edition, including a new chapter on "Examination of the Skin."

PHYSIOLOGY OF THE EYE, ed 4, by Francis Heed Adler, MD, Mosby, 1965. $18.75

As with the previous editions, this edition describes in simple terms the way the eye functions. The author views physiology as an ever-changing science. As soon as one question is answered, another is automatically posed; hence the need for new editions.

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The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic history of blood dyscrasia. Because of th increased possibility of toxic reactions, t drug should not be given when the patien cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® al are contraindicated in patients with glaucoma.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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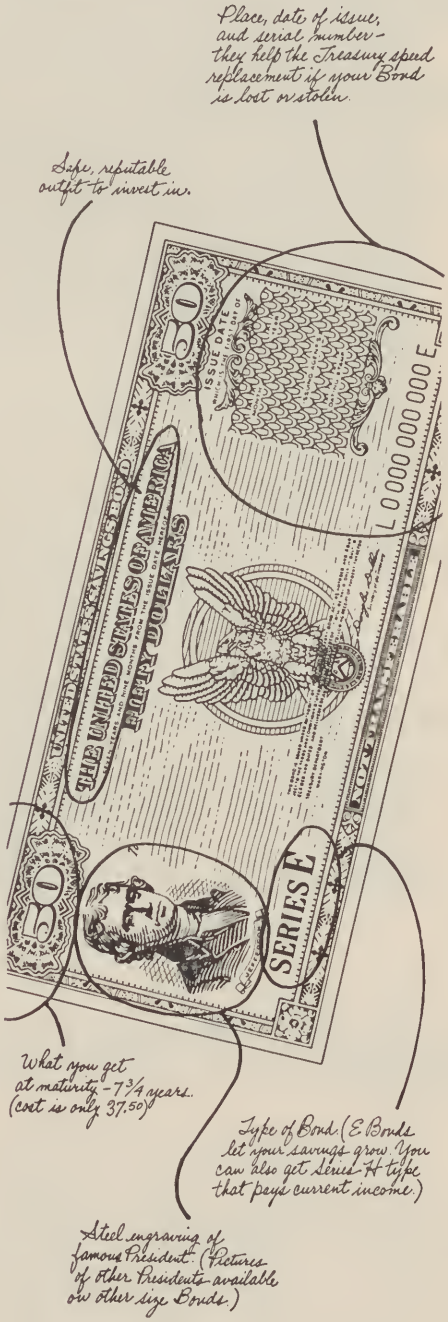
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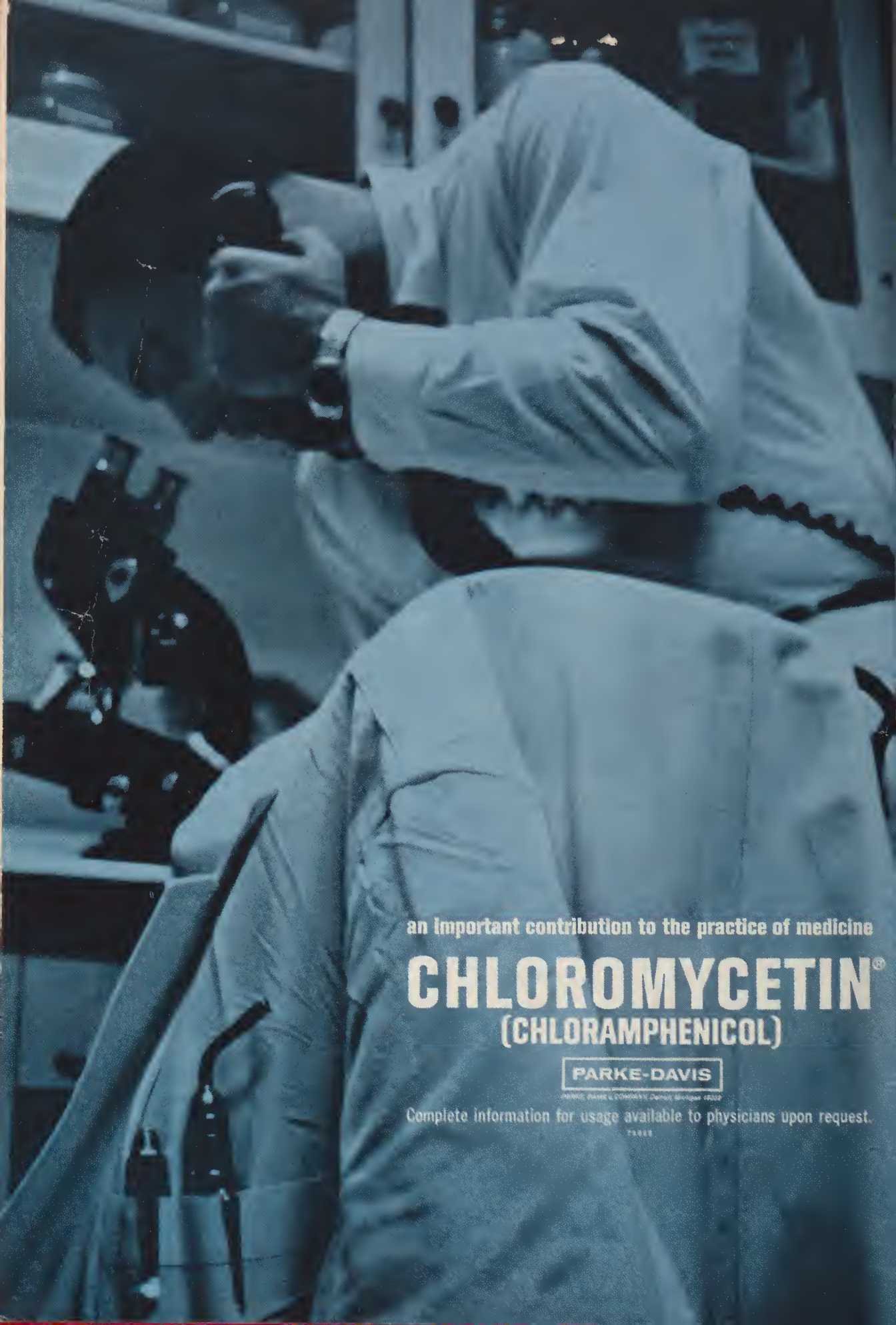
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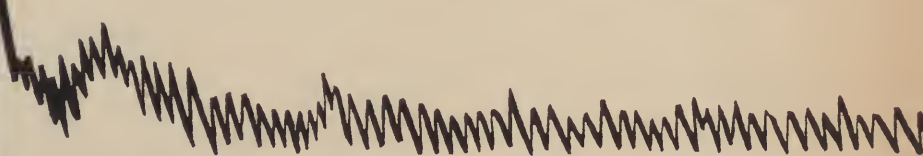
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"Psychiatric Services in a Generol Hospital," Lauren H. Smith, MD, Prafessar af Psychiatry, University of Pennsylvania Medical Schaal.

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1. "Evolution and Meosurement of Hand Function." Douglas Corroll, MD, Chief of Physical Medicine and Rehobilitotion, Boltimore City Hospitals.
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Under direction of Cyrus L. Blanchard, MD, and Richard D. Richards, MD: The practical problems of ophthalmology and otolaryngology with which the practicing physician must be conversant.

3. NEUROPATHOLOGY FOR PATHOLOGISTS—December 6-11

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Chairman — William L. Stewart, MD, Chairman, Committee on Postgraduate Education, Preventive Medicine and Public Health, Medical and Chirurgical Faculty

10:00 - 10:10 **Welcome**
William J. Peeples, MD, Commissioner, Maryland State Department of Health

10:10 - 10:50 **Perspective of Salmonellosis**
Philip S. Brachman, MD, Chief, Investigations Section, Epidemiology Branch, Communicable Disease Center

10:50 - 11:30 **Occurrence and Sources of Contamination of Foods for Human Consumption and of Animal Feeds and Ingredients**
Kenneth D. Quist, DVM, Chief, Animal Breeding and Holding Unit, Laboratory Branch, Communicable Disease Center

11:30 - 12:00 **Epidemic Patterns with Emphasis on Hospital and Institutional Infections**
Philip S. Brachman, MD

12:00 - 1:00 Lunch

* * * *

AFTERNOON SESSION

Chairman—John H. Janney, MD, Chief, Division of Epidemiology, Maryland State Department of Health

1:15 - 2:00 **Role of Public Health Team**
Martin Hines, DVM, Director, Division of Epidemiology, North Carolina State Board of Health

2:00 - 2:30 **Management of Cases and Carriers and Therapeutic Measures**
Richard B. Hornick, MD, Director, Division of Infectious Diseases, University Hospital, Baltimore

2:30 - 3:00 **State Programs and Activities**
from the viewpoint of the Environmental Hygienist—
Mr. James D. Clise, Supervising Sanitarian, Division of Food Control, Maryland State Department of Health
from the viewpoint of the Microbiologist—
Elizabeth Petran, PhD, Chief, Division of Microbiology, Bureau of Laboratories, Maryland State Department of Health
from the viewpoint of the Epidemiologist—
Joseph Bell, MD, Consultant and Epidemiologist, Montgomery County Health Department

3:00 - 3:45 **Question and Answer Period**

3:45 - 4:00 **Summary**
Kenneth L. Crawford, DVM, Chief Public Health Veterinarian, Division of Epidemiology, Maryland State Department of Health

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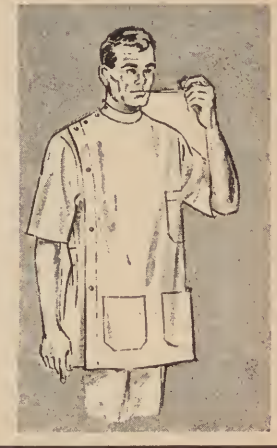
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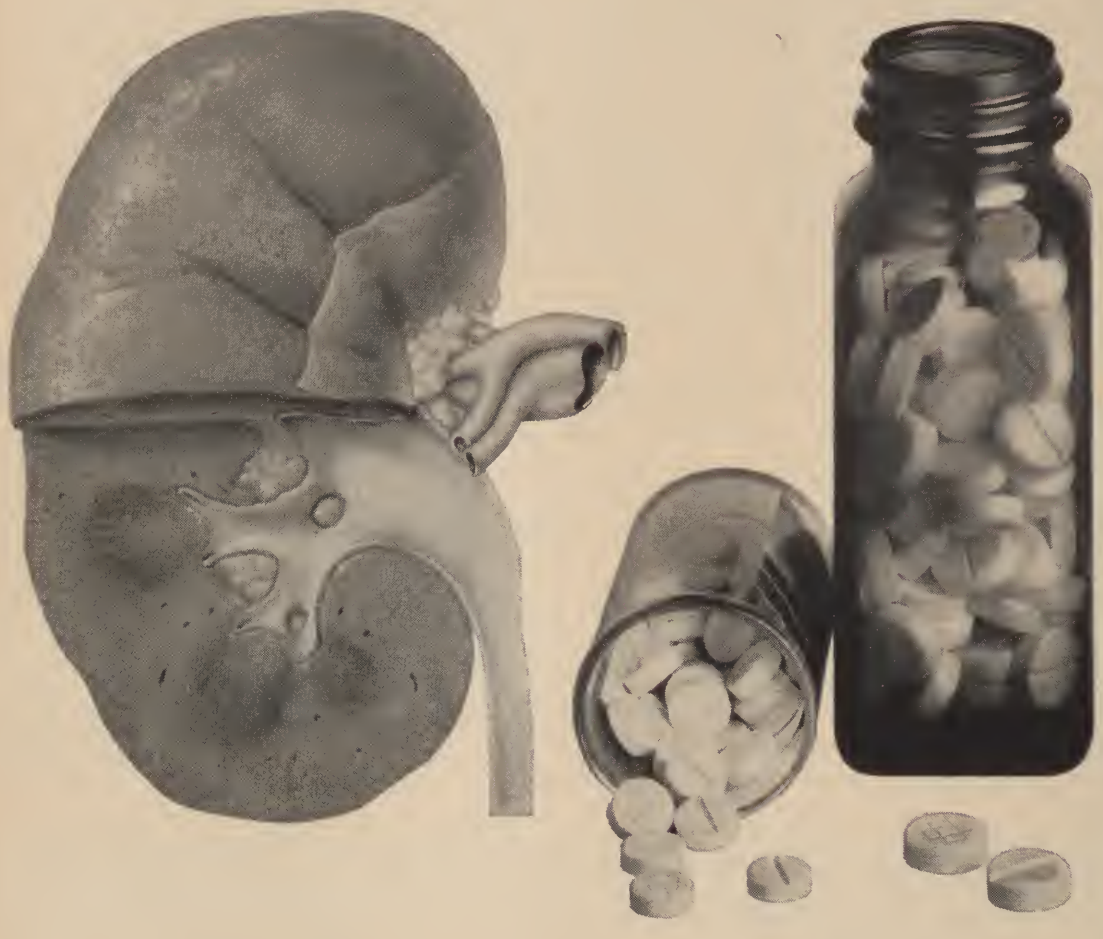
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Contraindications
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EXECUTIVE SECRETARY'S NEWSLETTER

September, 1965

NEWS NOTES

N. Edward Nachlas, M.D., and Alan Gill, M.D., are scheduled to present a paper at the VII International Congress of Otorhinolaryngology, in Tokyo, Japan.

A. Edward Maumenee, M.D., was elected head of the Section of Ophthalmology of the American Medical Association.

CONGRESS ON ETHICS

The AMA has announced a Congress on Medical Ethics and Professionalism at the Drake Hotel, Chicago, October 2 and 3, 1965.

Representatives of the Faculty will be in attendance at this meeting, but individual members are also welcome to attend. Details may be obtained through the Faculty office.

WELCOME BACK

We are pleased to welcome back the Florida Citrus Commission as an advertiser in the Maryland State Medical Journal.

INTERNISTS MEETING

The scientific program of the Maryland Society of Internal Medicine on Monday, October 4, 1965, will be held in Osler Hall, in the Faculty Building. Abraham Osler, M.D., Associate Professor of Microbiology at Johns Hopkins University School of Medicine will talk on In Vitro Studies of Human Allergy.

SALMONELLOSIS SEMINAR

Osler Hall will also be the site of a Seminar on Salmonellosis on Friday, October 8, sponsored jointly by the Faculty and other interested groups. The session is limited to 200 in registration. Full details may be obtained through the State Health Department or the Faculty office.

HEART SESSION

A medical symposium on Coronary Disease and Myocardial Infarction is scheduled by the Heart Association of Maryland on September 22, at the Washingtonian Country Club, Gaithersburg.

MEDICARE PAMPHLETS

Physicians who may still have Eldercare/Medicare pamphlets in their offices are urged to

dispose of them in order that confusion is not created in the minds of the patients who may see them.

RADIO SERIES

All radio stations in Maryland are being invited to avail themselves of a 26-week radio interview series. Titled, "Subject: Your Health", the interviews are with prominent physicians throughout the country on medical subjects proved to be the most popular and of the greatest interest to most people.

PEDIATRIC SURVEY

The USPHS is conducting a Health Examination Survey of a sample of the child population (6 - 11 years) for a 3 week period beginning October 25 in Worcester County.

This is similar to a survey conducted some time ago of the adult population, and one held in April 1964 of children in the Baltimore City area.

A brief report of the findings will be sent to the child's physician, if the parent so requests. No part of the examination will be disclosed directly to the child or his parents.

The data collected is to be used for scientific purposes only. Further details are available from the Faculty office.

PROJECT VIETNAM

The AMA is cooperating with the U. S. Government, on direct appeal from President Lyndon B. Johnson, in providing physicians for the people of South Viet-Nam.

Teams of 20 physicians will be sent into Viet-Nam for periods of just 60 days. The teams will be divided into four groups; each being assigned to a hospital now being operated under the AID program. Immediate need is for gp's, general surgeons and orthopedic surgeons.

The service is on a voluntary basis, although transportation from home and return via commercial airline, a nominal per diem, housing, meals and other needs will be supplied. The federal government has also assured that all volunteers will be granted the same privileges, courtesies and priority provided government personnel in the area.

Further details to those who may be interested are available from the Faculty office.

John Sargeant

Executive Secretary

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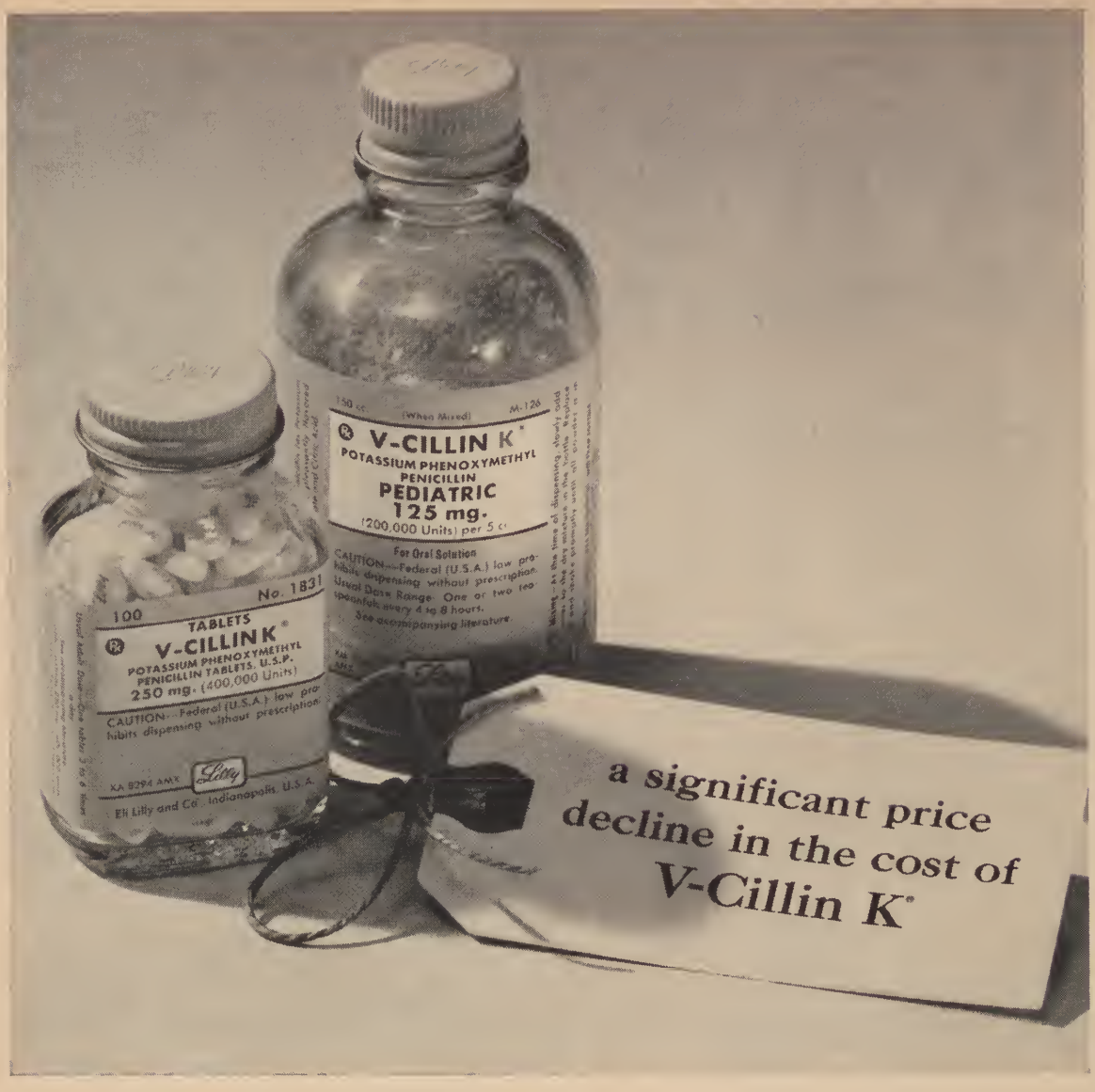
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Maryland State Medical Journal
Vol. 14, No. 9
September, 1965

SOMERSET COUNTY ILLNESS

This report clinically describes an epidemic illness which occurred on the Eastern Shore of Maryland in January, February, and March, 1963. The illness was characterized primarily by multiple diversified symptoms, including upper respiratory infection, generalized adenopathy, painful hepatosplenomegaly, gastrointestinal disorders, emotional disturbances, and marked prolonged fatigue. The most remarkable feature of the illness was the fact that in spite of marked hepatomegaly there was not the disarrangement of liver function that one would expect. There was an unusual degree of relapses for what appeared to be a benign illness.

EVERETT C. SUTTER, MD

In January, 1963, an epidemic illness started in the upper portion of Somerset County. The clinical onset superficially resembled that of influenza and infectious mononucleosis. The syndrome appeared to be characterized by a stubbornly protracted course in many patients, with relapses and recrudescenses which appeared to be precipitated by exertion and menses.

This report describes the clinical aspects of this epidemic. It is realized that such description can in no sense be considered definitive due to the absence of an etiologic diagnosis. It appears worthwhile, however, to bring these observations to the attention of the medical profession, since there is indication that foci of the illness are present in many areas of the United States.[1] The relentless progress of the illness through the community and the apparent high attack rate suggest that

Table 1
Distribution of Cases as a Function of Age and Sex

Male	No.	%
Under 1 year	12	1.4
1 to 10 years	101	11.3
10 to 20 years	63	7.0
20 to 30 years	28	3.1
30 to 40 years	26	2.9
40 to 50 years	54	6.0
50 to 60 years	58	6.5
60 to 70 years	30	3.4
70 and over	29	3.3
Female		
Under 1 year	9	1.0
1 to 10 years	107	12.0
10 to 20 years	84	9.4
20 to 30 years	44	4.9
30 to 40 years	67	7.5
40 to 50 years	55	6.1
50 to 60 years	53	5.9
60 to 70 years	40	4.5
70 and over	29	3.2

this illness may constitute a serious and widespread public health problem in the future. Studies to delineate its etiology are now underway.

OBSERVATIONS

The criteria for diagnosing this syndrome were enlargement or tenderness of the liver or spleen, generalized adenopathy, neurasthenia symptoms, normal blood count, and severe fatigue of several weeks duration. The illness occurred in all age groups (Table 1).

Clinical Course: The onset in about one-third of the cases was insidious, with lassitude, malaise, headaches, low grade fever, pain in the back, and increasing fatigue; in others there was an acute onset of high fever, aching, chills, severe cough, and associated weakness. While some patients presented fragments of the syndrome, others have demonstrated the entire range of symptoms. Marked variations were encountered from case to case not only in severity but also in the evolution and entire course of the illness. The signs and symptoms in individual patients varied from day to day, particularly during the subacute stage.

Symptoms: The most common complaints (Table 2) were severe cough, often with hemoptysis and usually dry and non productive; nose bleed; pain in the chest, "band like and squeezing"; menstrual disturbances, such as irregularities, unusually severe bleeding, and spotting; headaches, described as pain behind the eyes or in back of the head which were very severe; abdominal pain; dizziness; fatigue; stiffness in the neck and back; myalgias; emotional disturbances, such as irritability and depression, mental

Table 2
Frequency of Symptoms*

	No.	%
A. Upper Respiratory Symptoms:		
Sore throat	311	35
Rhinitis	196	22
Cough, severe	534	60
Wheezing	422	46
Tightness in chest	391	44
Chest pain	286	32
Flatulence	544	61
B. Gastrointestinal Symptoms:		
Nausea	312	35
Vomiting	206	23
Diarrhea	216	24
C. Neurological Symptoms:		
Dizziness	308	35
Depression	389	44
Mental confusion	205	23
Blurring of vision	189	21
Somnolence	612	69
Unprovoked crying spells	189	21
Undue irritability and anxiety	517	57
D. Hemorrhagic Symptoms:		
Hemoptysis	89	10
Nose bleed	76	8
Tarry stools	7	0.8
Menstrual disturbances	37	4
Bleeding from tonsils	2	0.2
E. Other Symptoms:		
Abdominal pain	718	81
Headaches severe	416	47
Pain in back	453	51
Increasing fatigue	722	81
Pain in and about ear	416	46
Vasomotor disturbances	454	51

*** These 889 patients were seen between January 28 and March 27, and it was from this group that the throat washings and blood sera were taken.**

Table 3
Frequency of Physical Findings

Finding	No.	%
Lymphadenopathy	889	100
Abdominal tenderness	492	55
Palpable liver	721	81
Tender liver	801	90
Spleen tender or palpable	516	58
Fever high	356	40
Fever low AM—Elevated PM	467	53
Conjunctivitis	608	67
Tremor of extremities	209	23

confusion; vasomotor disturbances, such as subjective and objective sensation of intermittent coldness and warmth; cutaneous sensory disturbances as localized numbness and tingling which did not conform to segmental distribution; gastrointestinal disorders, such as anorexia, diarrhea, projectile vomiting, constipation, flatulence; somnolence; conjunctivitis; and blurring of vision.

Physical Findings: The most common physical findings (Table 3) were the tenderness and enlargement of the liver, which was found to be tender or painful to deep abdominal palpation in 90% of patients; in most of these it was found to be enlarged. The spleen was found to be either tender or palpable in 58% of the patients, more often tender than enlarged. Generalized abdominal tenderness was present in 55% of patients. Lymphadenopathy was present in all cases, tender in about half the cases and exceptionally large in 32% of cases. The posterior cervical nodes usually appeared first and were almost always tender, small, and soft. Anterior cervical nodes were usually large and extremely tender. In patients with insidious onset, instability of body temperature, depression of morning temperature, and elevated afternoon temperature were common. In those with an acute onset, temperature was high at the onset and later became unstable.

Laboratory Findings: Hematologic studies were normal with the exception of a few increased lymphocytes and a few cases of mild leucocytosis. Of 28 patients on which SGPT were done (Table 4) nine showed elevation of SGPT above 30. Eight of the 28 patients were considered too early in the course of the illness and seven too late in the recovery stage to show an elevation. Of 10 blood samples studied by the State Health Department, none showed positive cephalin flocculations.

The following case histories are included to illustrate the basic similarities as well as the marked and unusual differences between cases in symptoms, physical findings, and course of the illness.

Case 1. A 40-year-old woman developed an acute upper respiratory infection on January 15, 1963, and she was first seen five days later. Complaints consisted of head cold, left upper quadrant abdominal pain, diarrhea, and the onset of low back pain. Accompanying these symptoms was a periodic sensation of "numbness" in the right leg, a progressive tendency toward manual clumsiness, and an increasing feeling of tension. She had been extremely nervous and depressed.

Physical examination revealed a palpable, tender liver and generalized tender lymphadenopathy. Laboratory findings revealed WBC 4,200, Hb 12.6, neutrophiles 62%, lymphocytes 36%, monocytes 2%. She was treated with chloramphenicol and bedrest for five days and was allowed to return to part-time employment.

She returned on January 28 complaining of a cough, nausea, flatulence, dizziness, mental confusion, undue irritability, anxiety, and marked increasing fatigue. Physical examination revealed a tender liver and tenderness over both kidneys. Urinalysis was negative. Bedrest was advised, and she was asked to return in one week.

She was next seen on February 20, when she complained that she had had three menses in the past month. She was started on norethynodrel for the abnormal bleeding.

On March 20, she was seen for a recurrence of the upper respiratory infection and a severe dry cough and sputum streaked with blood. She was continued on bedrest and again seen April 1. Physical examination was then normal, and she was allowed to return to full-time employment. She was again seen on April 15, complaining of severe fatigue, recurrent headaches, and difficulty sleeping. At this writing, physical examination is normal and patient complains of weakness and tiring easily.

Case 2. A 10-year-old girl developed fever, cough, sore throat, and general malaise on December 28, 1962. She was placed on chloramphenicol, bedrest, and analgesics. Her temperature remained high for four days, followed by insta-

bility of body temperature for 12 days. She was allowed to return to school on January 6.

Eight days later she developed temperature of 104, severe cough, abdominal pain, severe headache, and general malaise.

Laboratory findings revealed a WBC 5,200, and chest x-ray was compatible with virus pneumonia. She was again started on demethylchlortetracycline for six days. Blood counts were repeated on three occasions and were within normal limits. She was allowed to return to school on January 26.

On February 9, her temperature rose to 102 and she again developed severe cough, nausea, somnolence, and undue irritability and anxiety. WBC was again normal, urine normal, chest x-ray normal, and a blood was taken for heterophil agglutinations which was later reported as showing no rise in antibodies. She was treated with bedrest until February 20 and allowed to return to school with no physical education. Since then she has been seen on eight occasions with complaints of right upper abdominal discomfort, abdominal pain, recurrent sore throat, and nervousness.

Case 3. An 11-year-old boy was first seen on February 11, 1963, with an upper respiratory infection. Complete physical examination was not done, but he was treated with demethylchlortetracycline every six hours. He was next seen on March 1, complaining of nausea, vomiting, and fever. Temperature was 96, and physical exami-

Table 4

Liver Findings on 28 Patients at Random*

		Duration	Liver			
Age	Sex	Days	Size	Tenderness	SGP-T	Heterophil
39	F	21	—	1-plus	48	4
45	M	?	—	—	18	4
56	M	60	1-Fb.	2-plus	46	4
54	F	21	—	—	24	4
49	M	20	2-Fb.	1-plus	39	4
81	F	60	—	—	—	—†
18	F	60	—	—	30	4
52	F	30	—	—	—	—†
49	M	90	—	—	59	4
12	M	14	3-Fb.	1-plus	76	4
39	F	90	1-Fb.	1-plus	45	8
3	M	7	1-Fb.	1-plus	8	4
49	M	4	—	—	12	4
2½	F	7	1-Fb.	—	13	4
4	M	6	2-Fb.	1-plus	16	8
10	M	1	2½-Fb.	1-plus	11	4
10	F	90	2-Fb.	1-plus	20	4
16	F	14	2-Fb.	4-plus	—	—†
23	F	60	2-Fb.	—	17	4
12	M	14	—	—	22	4
42	M	60	1-Fb.	—	34	4
41	F	90	1-Fb.	1-plus	26	4
36	F	90	1-Fb.	1-plus	8	4
43	M	85	2-Fb.	—	28	4
12	M	8	—	—	32	4
13	F	3	1-Fb.	1-plus	22	4
6	M	3	1-Fb.	1-plus	14	4
4	M	1	2-Fb.	1-plus	16	4

* 28 patients seen by Prince and Adams on March 30, 31.

† No blood was drawn on these three patients.

Table 5

Patient	HAI antibody titer VS A2/Japan/305/57	A2/Bethesda/10/63	CF antibody titer with Adeno type 4 antigen
#1	20/20*	0/0	20/20
#2	20/20	20/20	0/0
#3	20/20	0/0	0/0
#4	0/0	0/0	0/0
#5	0/0	0/0	0/0
#6	40/40	20/20	80/80
#7	10/10	0/0	
#8	80/80	40/20	
#9	0/0	0/0	
#10	20/20	20/20	
#11	20/20	10/20	
#12	10/10	0/0	
#13	20/20	20/10	

* Acute (28 Mar '63)/Convalescent (2 May 63)

nation revealed enlarged cervical, axillary, and inguinal nodes, and enlargement of the liver two fingerbreadths below the right costal margin. He was given prochlorperazine suppositories for vomiting and placed on bedrest. On March 3 he began to bring up blood in the back of his mouth and he was admitted to the hospital, where the diagnosis of possible gastritis was made. He was discharged after four days to return to school.

During the next eight days he continued to bring up blood four to ten times daily in school. He was referred to an ear, nose, and throat consultant, who cauterized the tonsils on two occasions. Ten days later the tonsils were removed. The patient remained in the recovery room for four hours because of excessive bleeding. No cause for the excessive bleeding was found.

He returned to school five days after the tonsillectomy and six days later was brought home from school because of nausea and pain over the left upper quadrant. Examination on this date revealed large cervical lymph glands, shotty axillary and inguinal glands, and an enlarged and tender spleen. At this writing the child tires easily and is allowed minimal activities.

*Morris, J. A., PhD, chief, Section of Respiratory Viruses, National Institutes of Health, Bethesda, Md.

†Prince, A. M., MD, Associate member, The Wistar Institute of Anatomy and Biology, Philadelphia, Pa.; Adams, R. W., MD, Associate Professor of Pathology, Yale University Medical School, New Haven, Conn.

ATTEMPT AT ETIOLOGIC DIAGNOSIS

Acute sera (obtained March 28) and convalescent sera (obtained May 2)* from 13 patients were examined in HAI tests with an old (1947) and a new (1963) strain of influenza A2 virus. In none of the 13 pairs of serum were antibody rise against either of the virus strains demonstrated. Three of the serum pairs were devoid of antibody against the old strain, and seven of the pairs were free of detectable antibody against the new strain of virus. Six serum pairs were examined in complement fixation tests with adeno virus antigen (Table 5). In none was an antibody rise demonstrated. In addition, six pairs of sera were examined for presence of neutralizing antibody directed against the agent (SV20) recovered in 1956 in rhesus monkey kidney cell cultures inoculated with clinical material obtained from a patient with Ardmore disease. In none of the six pair of sera was a rise in antibody titer demonstrated. Serum obtained from two of the patients were free of SV20 virus neutralizing antibody.

Acute sera (obtained March 30) and convalescent sera (obtained May 20) from nine patients were subjected† to centrifugal and electron microscopic analysis procedure, and no virus particles were found. Heterophil agglutinations on 25 acute and convalescent sera (Table 4) and on 20 acute and convalescent sera obtained by

the State Health Department‡ showed low titer or no rise in titer. Sixteen sera were examined by the State Health Department for respiratory syncytial virus, adenoviruses, psittacosis, histoplasmosis, influenza A-A1-A2-B, Eaton agent Fa-CF, and Q fever. In none of the sera were they able to demonstrate an antibody rise. Tissue culture and animal inoculation of material obtained by Morris* and Dimijian‡ has failed to isolate an infectious agent with the exception of the isolation of the Eaton agent in one patient.

DISCUSSION

At this writing, five and a half months after the initial outbreak, the final prognosis in these patients is unknown. Most of the children have recovered, but only a few adults have fully recovered. They still are weak, tire easily, and some still are showing relapses and recrudescences.

The illness in some aspects resembles anicteric hepatitis,[2] although the attack rate of this illness is much higher; transaminases are much lower; and the neurasthenia symptoms and lymphadenomegaly are usually not as great as in anicteric hepatitis. The illness also resembles infectious mononucleosis[3] except for the low heterophil agglutinations, the high attack rate, the high incidence in all age groups, and the absence of jaundice.

Epidemic neuromyasthenia, "Iceland Disease,"[4-7] was at one time considered possible. This syndrome usually but not always occurs after the polio season.[8] Epidemic neuromyasthenia is more common in young and middle aged females and does not show the degree of liver tenderness and enlargement found in these patients. No paralysis was found in a single patient which is characteristic of epidemic neuromyasthenia.

The course and lymphadenopathy are similar to epidemic myalgia encephalomyelitis.[9] The present entity, however, more closely resembles Ardmore Disease.[10] In Ardmore Disease the liver function tests were similar to those found in this entity and did not show the derangement of liver function that one would expect with the marked enlargement of the liver. Some of the bleeding phenomena found in the present illness can possibly be explained by the fact that many did not take bed rest as prescribed.

Although it is realized that no etiologic agent has yet been established for this entity, a similar illness and course has been described in other areas of the United States. Personal correspondence suggests that the picture of a similar illness has occurred frequently since 1954 and 1955. It is also believed that a similar illness has been seen increasingly since 1956 in this area at about the same time of year. Many of these have been slow in responding, have shown relapses and recrudescences, and have shown no rise in heterophil antibodies. Six such patients treated in 1956, 1958, and 1960, still show marked fatigue. One, a 17-year-old white girl, has lost 52 days from school this year.

Apparent Epidemiology: Dames Quarter is a small community of about 300 people. Surrounding it are many other small communities. All of these are located near the Tangier Sound and Chesapeake Bay. Most of the male breadwinners are engaged directly or indirectly with the water. Some of the men work in a boat factory in Salisbury and some at a gas pump manufacturing company in Salisbury. Several are truckers of vegetables and fruit from Florida, Virginia, New Jersey, and New York. A large proportion of the wives work in shirt factories in Princess Anne, Fruitland, and Salisbury; some work in frozen food packing plants in Salisbury and Fruitland.

The epidemic appeared to have had its onset in a few patients as early as September, 1962. It appeared to increase in January, 1963, and to have reached epidemicity by the early part of February, 1963. It appeared to be tapering off, but during the week of March 18 at least 50 suspected cases and many relapses were again seen. By March 27, 1,281 cases had been seen by me and reported to the Health Department. Since that time a few new cases have been seen each week. Geographically, cases appeared to be limited mostly to the communities surrounding Dames Quarter, within a radius of 35 to 50 miles. Perhaps the only thing that can be said about mode of spread is that it is probably not an efficient respiratory agent like influenza, since this epidemic has lasted over a period of months and has progressed too slowly; probably not enteric

‡Dimijian, G. G., MD, Thorton, R., MD, Epidemic intelligence service officers. United States Dept. of Health Education and Welfare, assigned Md. State Health Dept., Baltimore, Md.

like polio because it occurred in the winter; probably not "oyster-borne" like some infectious hepatitis epidemics because most patients did not eat them. It should be pointed out that the high attack rate suggests low level of prior immunity in the community in all age groups. In some instances as many as 12 in one family were taken ill at the same time; in others, one at a time over a three to six week period became ill; in still others, only one member of a family became ill. The attack rate as determined by the State Health Department‡ by phone interviews was 28.2%. It appeared to have a higher attack rate in families of the lower income bracket.

There was no apparent difference in the attack rate in the factories in which some of the population worked than in the communities as a whole. Although the Eaton agent was isolated from one of 20 throat washings, it is believed*†‡, that a minority of cases were caused or aggravated by this agent.

This not being a reportable illness makes it difficult to establish the number of cases that occurred on the Eastern Shore of Maryland.

There is little reason to postulate a mass conversion reaction. The separate illnesses appeared at random intervals. Little apprehension about the medical problem appeared to exist among the general population, and cases occurring within the same household varied in their features and course. The apparent absence of a common exposure factor and the disproportionately high incidence among people from different communities weigh against a single exposure to an infectious or toxic agent but are consistent with a hypothesis of person to person transmission of an infectious agent. Confirmatory evidence for an infectious process, however, including an etiologic agent is lacking.

This illness occurred at the same time influenza was occurring in many states and was at first confused with it.

Chronicity: During the initial outbreak of the illness, the course appeared benign and gave no indication of the difficulties to be encountered. After the liver tenderness had disappeared and the temperature had returned to normal (this was a deceptive sign), the patients were allowed to return to work. This required from four to eight weeks. School children were allowed to return to school with the recommendation that the child did not receive any physical education for several weeks. At this time it was felt that this illness was a self-limited disease of viral etiology. The etiologic agent apparently attained a high degree of infectivity, waned for two to three weeks, then reached another high degree of infectivity similar to the epidemic reported by Shelokov.[4] No further difficulty was expected with the illness.

The temperature did not return to normal as previously thought, because the slightest exertion or onset of menses appeared to again cause an elevation of afternoon temperature. With regular exertion in the majority of patients some of the original symptoms would recur. Even the tenderness of the liver and spleen, which had disappeared, recurred again and again. The abdominal pain, which was first mistaken for peritoneal irritation, was later believed to be related to the abdominal musculature; chest pain was believed to be due to lesions in the intercostal or diaphragmatic musculature.

Dames Quarter, Md.

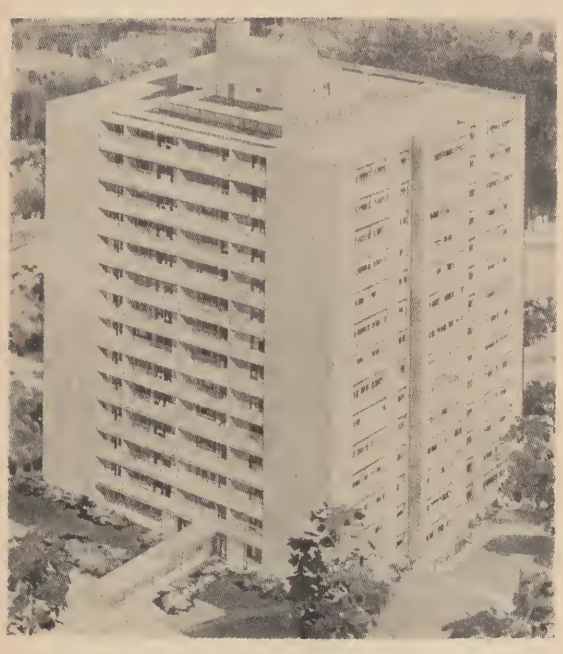
GENERIC AND TRADE NAMES OF DRUGS

Chloramphenicol—*Chloromycetin*
Demethylchlortetracycline—*Declomycin*
Norethynodrel—*Enovid*
Prochlorperazine—*Compazine*

REFERENCES

1. Personal communications.
2. Chauncey, R. L., and Zatz, L. M.: Sporadic Acute Anicteric Hepatitis Associated with Upper Respiratory Infection. *JAMA* 158:1013-16 (July 23) 1955.
3. Reed, J. T., and Helwig, F. C.: Infectious Mononucleosis: Analysis of 300 Cases with 3 Characterized by Rare Hematologic Features. *AMA Arch Intern Med* 75:376-80 (June) 1945.
4. Shelokov, A., et al: Epidemic Neuromyasthenia: Outbreak of Poliomyelitis-like Illness in Student Nurses, *New Engl J Med* 257:345-55 (Aug. 22) 1957.
5. Shelokov, A., and Henderson, D. A.: Epidemic Neuromyasthenia: Clinical Syndrome? *New Engl J Med* 260:754-64, 814-8 (April) 1959.
6. Acheson, E. D.: The Clinical Syndrome Variously Called Benign Myalgic Encephalomyelitis, Iceland Disease and Epidemic Neuromyasthenia. *Amer J Med* 26:569-95 (April) 1959.
7. Sigurdsson, B., et al: A Disease Epidemic in Iceland Simulating Poliomyelitis. *Amer J Hyg* 52:222-38 (April) 1950.
8. Leake, J. P., et al: Epidemiology of Poliomyelitis in California, 1934. *Amer J Pub Health* 24:1204-06, 1934.
9. Epidemic Myalgic Encephalomyelitis. *Brit Med J* 2:827-8, 1957.
10. Wilson, W. L., et al: Ardmore Disease. *AMA Arch Intern Med* 100:943-50 (Dec.) 1957.

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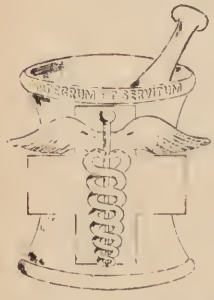
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THE MARYLAND PHYSICIAN AND HIS ALCOHOLIC PATIENT

A survey of Maryland physicians indicates that they are making a substantial effort to understand and to treat the alcoholic patient. Most physicians interviewed reported that few of their patients were known to mental hospitals or law enforcement agencies. It appears that physicians are reaching many alcoholics in the early stages of their illness.

Community support to the physician through the provision of supplemental medical, psychiatric, spiritual, and social resources, as well as an increased opportunity for special training through seminars or group consultation, can prevent some of the downward spiral among alcoholic patients to the level of the "revolving door" and "skid row."

LILLIAN M. SNYDER, ACSW

THE AMERICAN MEDICAL ASSOCIATION in 1954 proclaimed alcoholism a disease and placed on the physician responsibility for its diagnosis, treatment, and cure. Since then the physician's relationship with the alcoholic patient has been scrutinized. The Maryland Commission on Alcoholism, in 1961, undertook a survey of approximately 25% of all practicing physicians in Maryland most likely to be treating problem drinkers. It was found that the family physician plays an important part in the early recognition of alcoholism. Businessmen, wives of public officials, and even teenagers appeared to be turning to their family doctor for advice. It is apparent that the physician is in a strategic position to aid the busy executive before his family breaks up

Table 1
Distribution of Questionnaires

Type of Physician	Number of Physicians
Internists	132
Psychiatrists	48
General practitioners	442
Other specialties	19
Unknown	9
Total	650

or the teenager before he has a serious automobile accident.

PURPOSE OF SURVEY

The purpose of the survey of physicians was to describe what happens when the physician and his alcoholic patient meet. What prompts the alcoholic to seek medical attention from his physician? Under what circumstances does he or someone on his behalf call the physician? Does he select a physician who has a special interest in treating alcoholics? What types of therapy does the physician employ? Under what circumstances does the physician refuse to see the alcoholic patient? Can he admit his alcoholic patients to the general hospital with which he is affiliated? What recommendations would he make for community action?

STEPS IN MAKING SURVEY

A review of American and English literature revealed that 15 similar studies of physicians had been reported during the previous 18 years. Information from these earlier studies provided guidelines for this survey.

A 15-member advisory committee acted as a sounding board. On it were representatives of the Maryland Academy of General Practice, the Medical and Chirurgical Faculty of Maryland, the State Departments of Health and Mental Hygiene, the Health and Welfare Council of Baltimore Area, the Johns Hopkins Hospital, the University of Maryland School of Medicine, and the Monumental Medical Society. The research staffs from the State Departments of Health and Mental Hygiene agreed to provide technical assistance.

To help develop the questionnaire, 21 recovered alcoholics (17 men and four women) were asked about their experience in getting medical attention from their family doctors. All interviews were tape recorded. They reported a history of heavy drinking from five to 50 years. Respondents who had sought the advice of physicians in recent years described more satisfying experiences than those who had gone to their doctor before 1954. Most of these recovered alcoholics had gone to general practitioners; some had gone directly to internists or psychiatrists. One woman got help from her pediatrician and another from her obstetrician. Almost all the persons seen were professional people or were employed in skilled work. For most there had been a precipitating event which led to their seeking medical attention, such as blackouts or temporary loss of memory, serious automobile accident, failure in marriage, depression with suicide attempt, or excessive fears about the meaning of physical symptoms. Almost half made their first medical appointment for advice about liver trouble, nervousness, overweight, loss of memory, vitamin deficiency, loss of appetite, or insomnia. These alcoholics saw no relationship between these complaints and their excessive drinking, nor did their physicians. It was only in retrospect (one to ten years later) that they realized there had been a connection.

Also as part of developing the questionnaire, the names of 30 Baltimore City and county physicians were selected at random from the membership list of the Medical and Chirurgical Faculty to explore the physician's side of treating alcoholics. What type of physician treated the majority of alcoholic patients? At what stage of the illness did the alcoholic patient seek medical attention? Did the alcoholic recognize his illness? What did the physician do for him? With what results? None of the first 10 physicians telephoned treated alcoholics.

Another sample of 30 names was selected from the membership of the Maryland Academy of General Practice, of whom 19 were interviewed. Seven of those not interviewed said they did not see alcoholics; the others were not in private practice, had retired, were ill, or had moved out of the state. Interviews were tape recorded.

Physicians interviewed treated from two to 100 excessive drinkers. Each saw a few women. Most of their alcoholic patients were married and living with their spouses. Most of the patients were either professional people or skilled workers. Few had ever been hospitalized or arrested for drinking. One of the physicians said that several of

Table 2
Response of Physicians by Age Groups

Age Group	Total Physicians	Questionnaires Completed	Questionnaires Blank with Explanations	Physicians Retired, Moved, Deceased	Questionnaires Not Returned—Reason Unknown
25—39	134	98 (73%)	2	12	22
40—64	423	287 (68%)	5	48	83
65—90	84	50 (60%)	2	20	12
Total	641*	435**	9	80	117

*Age of nine physicians unknown.
**Includes 13 physicians spending more than half time in specialties not included in survey.

his patients (a personnel director in a large firm, a business man, and others) had come to him for advice about their drinking before they got into difficulty. They were aware of early symptoms of compulsive drinking.

Physicians generally agreed that both men and women try to hide their drinking problems as long as possible. No one seeks medical attention for a hangover. Most of the men sought help when they became frightened by such unusual symptoms as spitting up blood, chest pain, severe headaches, nervousness, blackouts, or malnutrition. Women had a greater tendency to seek medical advice about the excessive drinking problem itself; they often sought help about the time of menopause. Some were not getting along well with their husbands and saw no way out of their suffering. According to several physicians, husbands often tried to hide the problem by minimizing it or being overly critical and resentful. They would often undermine the physician's efforts.

A one-page questionnaire was prepared with the help of the advisory committee to be mailed to a selected group of internists, psychiatrists, and general practitioners. To test the response, questionnaires were first mailed to 70 physicians (every 40th name of internists, psychiatrists, or general practitioners on the membership list of the Medical and Chirurgical Faculty) on November 4, 1961. Within one week more than 40% of the physicians returned their questionnaires. With such encouraging response, the remaining questionnaires were mailed to every fourth physician (in general practice, internal medicine, or psychiatry) on the same list and to the total membership of the Maryland Academy of General Prac-

Table 3
Response of Physicians by Specialty

Specialty	Total Physicians	Questionnaires Completed	Questionnaires Blank with Explanation	Physicians Retired, Moved, Deceased	Questionnaires Not Returned Reason Unknown
Internists	132	96 (72%)	2	13	21
Psychiatrists	48	31 (65%)	1	4	12
General practitioners	442	295 (67%)	6	58	83
Other specialties	19	13 (68%)	0	5	1
Unknown	9	6 (67%)	0	1	2
Total	650	441	9	81	119

Table 4
Number and Sex of Alcoholic Patients in Physician's Practice by Specialty of Physician

Specialty	Number of Physicians	Male Patients	Female Patients	Total Patients
Internists	57	205	99	304
Psychiatrists	14	34	20	54
General Practitioners	228	1929	825	2754
Total	299	2168	944	3112

tice: a total sample of 650. Of this number, 531 replied or someone replied for them. Nineteen were excluded when they explained that they spent more than half their time in specialties not included in the survey. Others were deceased, ill, retired, or had moved out of the state. Some of the questionnaires were not completed. There were 422 completed questionnaires returned by 96 internists, 31 psychiatrists, and 295 general practitioners.

The percentage of physicians responding to previous surveys ranged from 16 in New York City, conducted by the New York Academy of Medicine in 1944, to 62 in Alabama in 1958. The response of Maryland physicians was 81%. Physicians under 40 years completed slightly more questionnaires than did their older colleagues.

A greater proportion of internists returned questionnaires than did psychiatrists or general practitioners, but they reported a smaller proportion of problem drinkers in their practice.

Physicians living in the country (rural villages under 2,500 population) returned a larger proportion of questionnaires than physicians living elsewhere.

SUMMARY OF FINDINGS

What proportion of physicians reported alcoholics in their practice?

More than 75% of all physicians who returned questionnaires reported having at least one alcoholic in their practice. The number of patients per physician ranged from one to 150. A total of 299 physicians were treating a total of 3,112 alcoholic patients in their practices. Eighty-two per cent of the general practitioners reported having alcoholic patients in their practice as compared with 64% of the internists and 51% of the psychiatrists. One third of patients were women.

Did the physician with a special interest in the alcoholic see more patients than the physician who did not have a special interest in this problem?

One physician in five expressed a special interest in the alcoholic patient. Those having a special interest saw an average of 15 patients in their practice as compared with an average of six alcoholic patients under care of other physicians.

Special interest was attributed mainly to the increasing number of this type of problem during many years of practice. Other reasons given were: exposure to the problem during medical education, during internship, during residency (especially in VA hospitals), or within the family. More than 96% of the physicians having a special interest were seeing one or more alcoholic patients. Nevertheless, almost 75% of the remaining physicians were treating problem drinkers.

Did many of the physicians have special training in treating the alcoholic?

About one physician in ten reported that he had received special training in the treatment of the alcoholic patient. Some stated that they had received training in medical school during internship in residency, or in post-graduate seminars.

Did the alcoholic seek medical attention on his own initiative?

About half of the excessive drinkers seeking the service of a general practitioner or internist during October, 1961, referred themselves, but only 27% of the patients seen by psychiatrists were self-referred. The next largest source of referral was family members, usually the spouse. Alcoholic patients were also referred to physicians by clergymen, Alcoholics Anonymous members, alcoholic clinics, police, other physicians, and psychiatrists.

Did alcoholic patients seek medical attention only for alcohol intoxication?

It has often been said that the alcoholic seeks



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IN BRIEF:

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Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Table 5
Number of Physicians With Number of Alcoholics in Practice
by Special Interest and Special Training of Physician

Interest and Training of Physician	Number of Physicians Reporting Indicated Number of Alcoholics in Practice							
	0 Patients	1-5 Patients	6-9 Patients	10-19 Patients	20-29 Patients	30 Patients	Total Physicians	Total Patients
1. Special interest & special training	2	7	0	6	0	4	19	388
2. Special interest & no special training	1	21	9	13	1	9	54	724
3. No special interest & special training	7	13	2	3	0	2	27	235
4. No special interest & no spec'l training	75	122	40	32	6	9	284	1,765
Total	85	163	51	54	7	24	384	3,112

help from his physician only when he is in the acute phase of his illness. Alcoholism is recognized as a chronic illness in which the alcoholic patient may or may not have periods of intoxication. Only about one third of the alcoholic patients described in the survey sought medical attention while intoxicated. This was true for both men and women.

Did alcoholic patients readily admit that they had a problem with drinking?

Only about 50% admitted to their physician that they had a problem with drinking (both men and women).

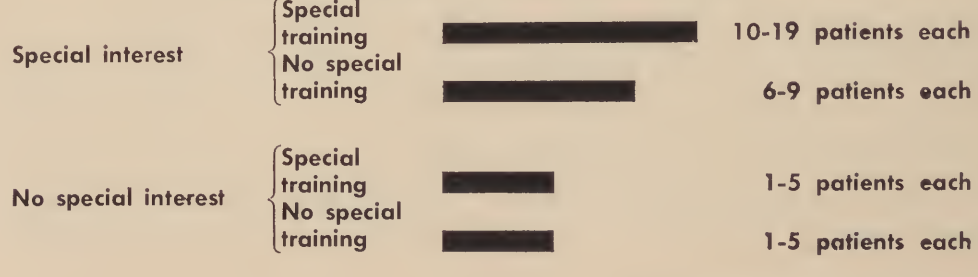
What types of therapy did the physician employ?

Fifty-seven per cent of all patients were given medication, counseling, or were treated in a hospital. These treatments were given separately or in various combinations. A larger number of alcoholic patients was given medication and counseling than any other single therapy or combination of treatments. The next therapy of choice was medication alone, and the third favored therapy was a combination of medication, counseling, and hospitalization.

About 50% of the physicians used no medication at all in treating their alcoholic patients. More than 75% of the psychiatrists used no drugs as compared with 65% of the internists and 37% of the general practitioners.

When drugs were used, the usual pattern was to prescribe tranquilizers (meprobamate, chlordiazepoxide, phenothiozine), sedatives (phenobarbital, paraldehyde, bromides, methyprylon, glutethimide, chloral hydrate), and vitamins. Sixty-six different drugs were named.

Table 6
Number of Physicians With Number of Alcoholics in Practice
by Special Interest of Physician in Alcoholism





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Under what circumstances did the physician refuse to see the alcoholic patient?

A few physicians stated that under certain circumstances they refused to see alcoholic patients. The main reason given was that the physician felt unqualified to treat the alcoholic. Other reasons cited were: "They don't respond to treatment." "They don't want help." "They cause trouble in the office."

Can the physician admit his alcoholic patients to the general hospital with which he is affiliated?

More than 33% of the general practitioners said that the hospital with which they were affiliated would accept patients with a primary diagnosis of alcoholism. Less than half reported that their alcoholic patients could not be admitted to the hospitals with which they were affiliated. Some were admitted under another diagnosis. The remaining 16% either did not have hospital privileges, did not know the hospital policy, or did not answer the question.

OBSERVATIONS

The problem drinker is beginning to seek the help of his physician earlier in his illness. Is the physician ready to meet this increased demand?

One often hears that physicians have little interest in alcoholics and therefore send these patients on their way as soon as possible. Others have the notion that the physician runs a "relay station"; that is, he acts as an arranger to assist a patient in gaining admission to a general hospital, a nursing home, a drying-out place, a halfway house, or a psychiatric hospital. Although there may be some truth to these impressions in individual cases, this survey did not substantiate them.

Maryland physicians are providing a substantial amount of attention and treatment to problem drinkers. More than 50% of the physicians who returned questionnaires had 10 or more alcoholic patients in their practice.

Few physicians have developed a tested regime in treating alcoholic patients. Some are convinced, however, of the ingredients which contributed to their successes. Physicians on the whole treated only those patients who were well known to them. Some had been known throughout their lifetime, and their alcoholic sons and daughters were being treated. Therapy for the problem drinker was considered in the light of the total medical picture of the patient and in relation to his family and economic demands. The physician frequently acted as an agent to keep his patient functioning in his role as family member and job holder as long as possible. There was a strong tendency to try to keep the problem drinker out of a hospital or any institution which would immobilize him socially and create other complications.

Problem drinkers sought medical advice at all stages in their illness, from the young adult whose alcoholic father was worried about the repetition of his illness in the next generation to the elderly retired couple who had little outside interest in life except to drink together.

Many alcoholics who were interviewed before the survey had mixed feelings in approaching their physicians. They felt ashamed to admit their excessive drinking, which to them was identified with skid row. But at the same time they felt confident in the knowledge and skill of their physicians. Some refused to accept the diagnosis of alcoholism, but one was relieved to hear that he was an alcoholic as this explained his troubles. Five alcoholics stated that neither the physician nor the alcoholic attached much importance to the excessive drinking.

None of the alcoholics stopped drinking after seeing a physician for the first time. One alcoholic said she had decided to stop drinking before seeing her physician, but it took her seven years to achieve sobriety. Seeing her physician, however, was the beginning of a chain of events which eventually led to the motivation and the will and courage to risk herself in a new way of life. Another alcoholic who had completed five years of psychoanalysis considered it a failure because she had not learned how to drink like other people. After she joined Alcoholics Anonymous, however, she began to realize that her treatment had been of considerable value in developing self-esteem and insight into her difficulties.

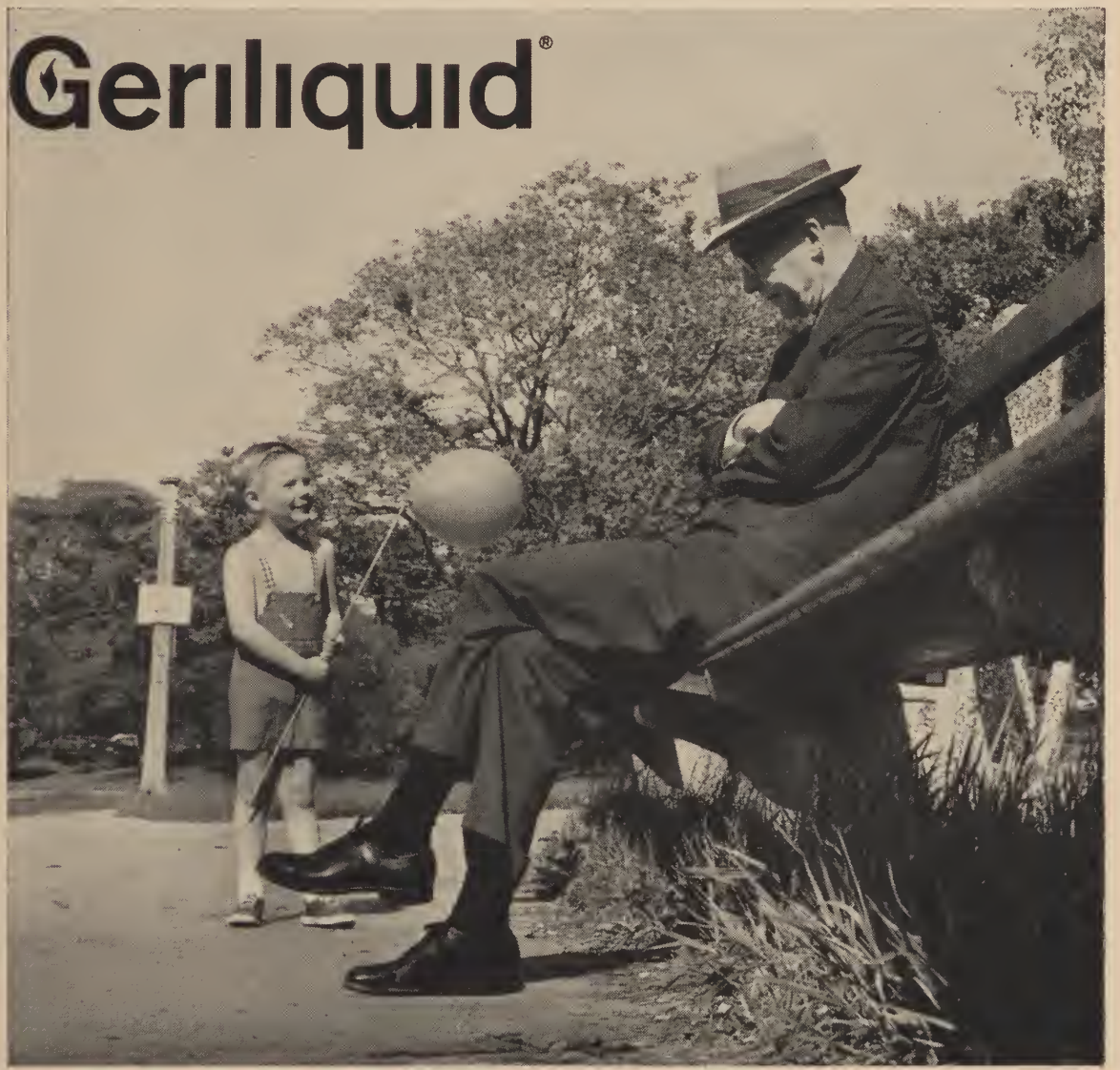
Without exception each of the 19 physicians interviewed before the survey saw problem drinking quite closely related to the way the individual deals with pressures in his life. Many of their male patients were unhappy in their work or were having marital difficulties. The stress and strain of economic survival among the Negro patients was uppermost in the minds of some physicians.

Physicians on the whole thought they could

when even southern sun fails to warm cold hands and feet

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Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

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recognize the alcoholic almost as soon as he entered the office. He is tense and under a strain; he is often shaken and undernourished. The physician usually pursued the discussion until the patient was ready to talk about his problem drinking. Many patients were relieved. They welcomed the opportunity to talk. The majority of physicians interviewed thought the most important aspect of their treatment was the long talk with the patient and members of his family. Physicians usually referred patients with deep-seated psychological problems to psychiatrists.

Little has been known about where the alcoholic woman goes for help. She is seldom seen on skid row. She is infrequently found drunk in a bar. She is not often arrested by the police. Female alcoholics make up only one in six of the alcoholics discharged after the first admission to a state mental hospital in Maryland (during the year ending June 30, 1960). Women make up a greater percentage of patients treated in private psychiatric hospitals and nursing homes than in the state mental hospitals. This survey shows that they constitute a substantial proportion of alcoholics (33%) treated by private physicians in Maryland. Moreover, almost half of the problem drinkers seen by psychiatrists were women.

COMMUNITY ACTION RECOMMENDED BY PHYSICIANS

Almost 50% of the physicians made one or more recommendations for community action. The need for a specialized treatment center was most frequently mentioned. Other recommendations included: more general hospital facilities, more psychiatric resources (especially consultation during times of emergency), more control of the sale of liquor, especially to minors (a few physicians favored return to prohibition), tighter control of the drinking driver, more research (organic and biochemical research as well as more research into underlying reasons for abuse of alcohol), more follow-up of patients, more family counseling, better housing, and more opportunity for employment (especially among the young people).

Acknowledgment is made of the assistance of Professor Harrison M. Trice, New York State School of Industrial and Labor Relations, Cornell University; Arthur Kraus, ScD, associate director, Office of Program Planning, Research and Development, New York City Health Dept; and Miss Frances Mitchell, volunteer, Baltimore Chapter, American Red Cross.

A substantial number of physicians stressed the need for more education about alcoholism. Education should be provided not only to professional groups but to the alcoholic patients and their families and to the public in general. Many physicians thought that alcoholics should be treated by physicians who have special training and interest in their treatment.

Most of physicians who commented on Alcoholics Anonymous reported that it had been of great help to their patients. Physicians expressed praise for some of the community services which have recently become available to alcoholic patients.

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REFERENCES

1. New York Academy of Medicine, Committee on Public Health Relations: A survey of facilities for the care and treatment of alcoholism in New York City. *Quart J Stud Alc* 7:405-438, 1946.
2. Riley, J. W., Jr., and Marden, C. F.: The medical profession and the problem of alcoholism. A cross-section survey of New Jersey physicians made for the New Jersey Commission on Alcoholism and Promotion of Temperance. *Quart J Stud Alc* 7:240-270, 1946
3. California Medical Association: Alcoholism. Studies by a special committee of the California Medical Association. *Calif Med* 72:40-56, 1950.
4. Straus, R.: Community surveys; their aims and techniques with special reference to problems of alcoholism. *Quart J Stud Alc* 13:254-270, 1952.
5. Hayman, M.: Current attitudes to alcoholism of psychiatrists in southern California. *Amer J Psychiat* 112:485-495, 1956.
6. Waisaman, C. E., and Mulford, H. A.: Alcoholism and Iowa physicians. *J Iowa Med Soc* 47:565-569, 1957.
7. Babow, I., Watts, M. S. M., and Samuel, B.: Experience with a community health council questionnaire for practicing physicians. *JAMA* 168:268-270, 1958.
8. Passey, G. E., and Pennington, D. F., Jr.: A survey of medical and hospital treatment of problem drinkers in Alabama. Phase one of a program of research for the Alabama Commission on Alcoholism. 56 pp mimeo. Montgomery, Alabama, October, 1958.
9. Missouri State Medical Association Committee on Alcoholism: Alcoholism in Missouri. A statement of the problem and recommendations. 130 pp. St. Louis, 1958.
10. First, R. J.: Alcoholism knowledge in four helping professions. 29 pp mimeo. State Board of Alcoholism. Lansing, Michigan, 1960.
11. Committee on Alcoholism for Greater New Orleans, Inc.: Questionnaire for physicians, 1961.
12. Cincinnati Council on Alcoholism: Confidential questionnaire for physicians. 1960.
13. Medical Society of the County of Erie, Special Committee on Problems of Alcoholism: A report on the 1960 survey of physicians in Erie County, New York State, on the problem of alcoholism. 5 pp. Buffalo, 1961.
14. Parr, D. *Brit J Addict* 54:25, 1957.
15. Glatt, M. M.: *J Coll Gen Pract* 3:392, 1960.
16. Block, M. A.: Alcoholism is a disease. *Today's Health*, 1956.

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COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

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RATIONALE IN THE TREATMENT OF DIABETIC ACIDOSIS AND COMA

Diabetes mellitus is a disturbance of the carbohydrate metabolism due to improper utilization and insufficiency of insulin. The increased catabolism of the fatty acids during diabetic crisis causes the accumulation of ketone bodies which in turn produce ketosis, acidosis and coma.

Treatment is designed to: 1) interrupt metabolism of the fatty acids and encourage the return to the physiological metabolism of carbohydrates; 2) eliminate the ketone bodies which the patient's body cannot metabolize; 3) correct the dehydration; 4) restore electrolyte balance.

SAMUEL STERN, MD

Diabetes mellitus is a disturbance of the carbohydrate metabolism which is characterized by improper utilization and insufficiency of insulin.[1] Patients suffering from this disease, in its classical form, require supplemental external insulin to support their carbohydrate metabolism. In mild cases, oral hypoglycemic agents or low calorie diet will suffice.

Diabetes is generally a stable disease, but under stress an acute insufficiency of insulin ensues, which in turn impairs the carbohydrate metabolism.[2] As a result, the liver catabolizes large amounts of fats and the organism accumulates excessive quantities of Acetyl Co A and ketones.[3] The ketones are intermediary products of fat metabolism; however, two of these ketones, the beta-hydroxy-butyric acid and the aceto-acetic acid, are four carbon highly acidic chains, and their accumulation tends to lower the blood pH. It is the accumulation of these acids in the blood which is responsible for ketosis, then acidosis, and finally diabetic coma.

In ketosis the patient usually complains of nausea, vomiting, and vague chest and abdominal pains. As a result of the impaired glucose metabolism, hyperglycemia will develop. When the level of blood sugar rises above the kidney threshold for glucose, glucosuria may be found. As the metabolism of the fatty acids progresses and ketone bodies accumulate, their presence in the blood and urine can be detected by testing for acetone. The blood buffer systems, namely the alkali reserve (sodium, potassium, magnesium, calcium, etc.), neutralize the aceto-acetic and beta-hydroxy-butyric acids.[4] In consequence, the CO_2 combining power decreases while the blood pH continues to be maintained. This is still a compensated phase. Vigorous treatment at this stage, directed first at the causal symptoms and secondly at increasing the amount of insulin and fluid intake, can reverse the process and carbohydrate homeostasis may be restored.

If the ketotic process continues unabated, a point is soon reached where the buffer systems are depleted and the patient proceeds into diabetic acidosis or the decompensated phase. At this stage the CO_2 combining power is low and the concentration of ketone bodies in the blood is high. The potassium normally is an intracellular cation being preserved intracellularly by combination with glycogen. As the glycogen stores are depleted, the potassium tends to become extracellular and participates in the neutralization of the ketone bodies. A high renal water and electrolyte loss develops.

Clinically a patient in diabetic acidosis will



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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

therefore be dehydrated. His tongue and skin are dry; his skin is somewhat flushed because of the hemoconcentration; his eyeballs are soft; some degree of tachycardia and a slight fever of dehydration may be found; his breathing is deep and heavy (Kussmaul breathing); and acetone may be detected on his breath. These manifestations will be accompanied by the classical symptoms of diabetes.

Laboratory findings in acidosis will indicate glucosuria, acetonuria, hyperglycemia, hyperpotassemia, small changes in the sodium, often an extremely low CO_2, and low or normal chlorides. Whenever persistent vomiting and diuresis cause excessive loss of chlorides, the blood CO_2 may compensate and close the anion gap. Blood CO_2 may then be normal, and occasionally even slightly elevated levels may be found.[4] It is important, therefore, to determine simultaneously the level of the chlorides and the CO_2.

When diabetic acidosis regresses into extreme with critically low blood pH and ketonemia of toxic level, consciousness may be lost and coma ensues. The laboratory results at this stage will be similar to those described above but of a more extreme character. Diabetic coma, in contrast to hypoglycemic coma, is a relatively slow developing condition. The patient, before entering the diabetic coma state, must first deplete his buffer systems, then develop acidosis, and only if he fails to receive adequate treatment will he enter the diabetic coma stage. In hypoglycemic coma, on the other hand, it is the rate of decline and level of blood glucose that determine the patient's state, and often the patient has little, if any, warning.

TREATMENT

Physiologically the beta cells secrete the equivalent of 40-50 units of crystalline insulin in 24 hours.[5] In spite of this fact, certain patients require thousands of units per day before the carbohydrate metabolism is restored.[6–13] The amount of insulin required varies depending on the patient's resistance to insulin. A safe approach is to start with 25 units of regular insulin subcutaneously.[1,14] This dose is repeated every half hour in severe acidosis.

If the patient is in shock or severe dehydration, it is common to add the first dose of 25 units of regular insulin to the first bottle of intravenous solution, for more immediate insulin effect. Within two to three hours the patient usually shows signs of improvement. Frequently the first sign is the subsidence of Kussmaul breathing. If after an hour or two the Kussmaul breathing seems to be aggravated, a double dose of insulin should be administered every half hour. Rarely will the physician have to resort to a larger dose than 25 units of regular insulin every half hour.[1,14]

Since large amounts of regular insulin have to be used in the treatment of diabetic acidosis and coma, it is imperative to supply the patient with adequate amounts of carbohydrates to prevent hypoglycemia.[1] To compensate for the patient's vomiting, prior to developing acidosis and coma, it is advisable to start the intravenous medication with 1000 cc of isotonic saline followed by 1000 cc of 5% glucose in water.[1,3,19,20] This combination should be alternated, and strict measurement of intake and output should be instituted.

Acidosis and coma are chemically dynamic states, in which the conditions of the blood and the patient change from one hour to the other. The chemical picture is likely to change markedly during a short period of time. Blood determinations will be of little or no value unless they are obtained within half an hour after the drawing of the blood. A close surveillance of the glucose and acetone levels may be achieved through frequent urinalysis. Urine specimens may be readily obtained from the acidotic patient. A Foley catheter should be introduced into a comatose patient until consciousness is regained.[1]

The urinary findings should be matched with an appropriate schedule of regular insulin doses. There are various schedules. A common and safe one is the following[1]: If the urine shows 4 plus glucose and 4 plus acetone, the patient should receive 25 units of insulin; if the urine shows 4 plus glucose and moderate acetone, insulin should be reduced to 20 units; if the urine shows 4 plus glucose and a trace of acetone, 15 units of insulin will suffice; if the urine shows 4 plus or less glucose and no acetone, insulin will not be required; if the urine is negative for glucose but is positive for acetone, no insulin should be given and the intravenous glucose should be accelerated.

It is advisable to maintain glucosuria as long as marked acetonuria exists. There is no immi-

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nent danger from moderate hyperglycemia[1]; on the other hand, sudden deaths have been recorded as a result of hypoglycemia while the patient was treated for diabetic acidosis.

Since the ketone bodies are excreted with the urine, the larger the urinary output the faster will be the drop in the level of the ketone bodies in the blood. The acidotic patient will excrete almost all the fluids that are given him; therefore, unless he is known to have severe cardiovascular or kidney disease, he should be able to tolerate large amounts of intravenous fluids. The patient may receive between 9-12 liters of intravenous fluids in less than 12 hours, and the physician need not be concerned about overloading the cardiovascular system as long as adequate diuresis is maintained. The more ketone bodies the patient eliminates the sooner the physiologic balance of the blood will be restored.

Patients who could tolerate and excrete 9 to 12 liters of intravenous fluids usually required about eight hours to become alert and acetone free.[14] It is important, however, to administer isotonic infusions or correction of the dehydration, in particular of the intracellular compartment, will be delayed.

Electrolyte restoration is intended primarily to raise the pH of the blood and to recharge the buffer systems. These results can be achieved by infusing the patient with sodium salt of a weak anion which is easily metabolized.[4,14] One sixth molar of sodium lactate solution or sodium bicarbonate are used for this purpose. The lactate is easily metabolized through the krebs cycle while the CO_2 of the sodium bicarbonate is blown off through the alveoli.[4] The remaining sodium helps raise the pH of the blood and increases the alkali reserve. Sodium bicarbonate seems to be more effective than sodium lactate, possibly because the lactic acid is a three carbon acid with an asymmetric middle carbon. Consequently, two isomers of lactic acid are found in nature; in the human body the only form found is "the Sarcolactic Acid." The commercial sodium lactate is a racemic solution composed of the two isomers. In consequence, the patient who is given a sodium lactate solution is able to metabolize only part of the lactic acid, and the rest has to be eliminated.

There is little more that can or should be done for the transitional hyperpotassemia. A good diuresis will eliminate large amounts of potassium, while the restoration of the carbohydrate metabolism will help the potassium shift into the cells. Upon the first signs of improvement, the clinician should be on guard for hypopotassemia, which is characterized by weakness, muscle flaccidity, and, in extreme cases, periodic paralysis. This condition can be avoided, however, by giving the patient citrus juices or broth as soon as he can tolerate liquids by mouth.[4,15–18]

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REFERENCES

1. Tolstoi, E.: *The Practical Management of Diabetes.* Springfield, 1953.
2. Hinkle, L.E., Jr. and Wolf, S.: Importance of Life Stress in Course and Management of Diabetes Mellitus, *JAMA* 148:513, 1952.
3. Mirsky, I.A.: The Etiology of Diabetic Acidosis, *Proc Amer Diabetes Asso* 1:51, 1941.
4. *Diabetes:* A scope Monograph On The Nature, Diagnosis And Treatment Of Diabetes Mellitus, Published by the Upjohn Company, Kalamazoo, Michigan, 1961.
5. Goldner, M.G., and Clark, D.E.: Insulin Requirement of Man After Total Pancreatectomy, *J Clin Endocrinol* 4,194, 1944.
6. Joslin, E.P.; Root, H.F.; White, P.; Marble, A.: and Bailey, C.C.: not complete.
7. Harwood, R.: Diabetic Acidosis, Results of treatment in 67 consecutive cases, *New Eng J. Med* 245 1-9, 1951.
8. Duncan, G.C.: Diabetic Coma, A Therapeutic Problem, *Ann Intern Med*, 377:1188-96, 1952.
9. Pollack, H.: Treatment of Diabetic Coma, *Diabetes.* 2:177.
10. McCullogh, E.P.: Clinical Features of Diabetic Acidosis And Coma, *Diabetes* 2:171-76, 1953.
11. Root, H.F.: Treatment of Diabetic Coma, *J Chron Dis* 2:121-35, 1955.
12. Colwell, A.R.: Treatment of Diabetic Acidosis, *Arch Intern Med* 99:260-65, 1957.
13. Cohen, A.S., et al: Diabetic Acidosis: An Evaluation of the Cause, Course, and Therapy of 73 Cases, *Ann Intern Med* 52:55-86, 1960.
14. Holler, J.W.: Potassium Occurring During the Treatment of Diabetic Acidosis, *JAMA* 131:1186, 1946.
15. Martin, E.H., and Wertman, M.: Sodium Potassium, Magnesium, and Calcium Levels in Diabetic Acidosis, *J Clin Invest* 26:217, 1947.
16. Martin, H.E.: Hilier, P., and Wertman, M.: Potassium Deficits in Diabetic Acidosis with Particular Reference to Problems of Therapy, *Proc Amer Diabetes Asso*, 10:161, 1950.
18. Martin, H.E., et al: Etiology and Treatment of Potassium Deficits, *JAMA* 147:24, 1951.
19. Mattor, E.: Physiopathological, Clinical and Therapeutic Aspects of Diabetes Coma, *Arq Cir Clin Exp* 61:210, 1949.
20. Rabinowitch, I.M., Fowler, A.F., and Bensley, E.: The Use of Protamine Insulin in Diabetic Coma, *Canad Med Asso J* 37:105, 1937.
21. Addis, G.J., et al: Bicarbonate Therapy in Diabetic Acidosis, *Lancet* 2:223 (Aug 1) 1964.

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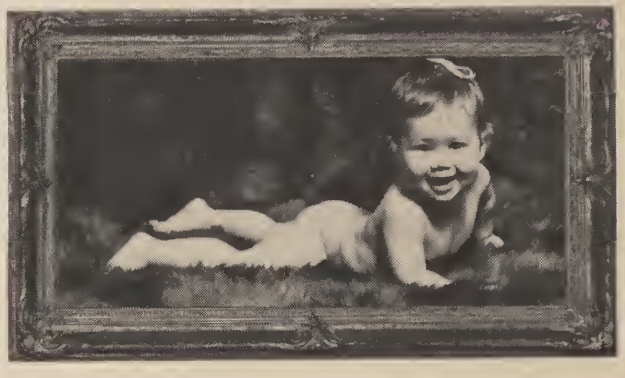
Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

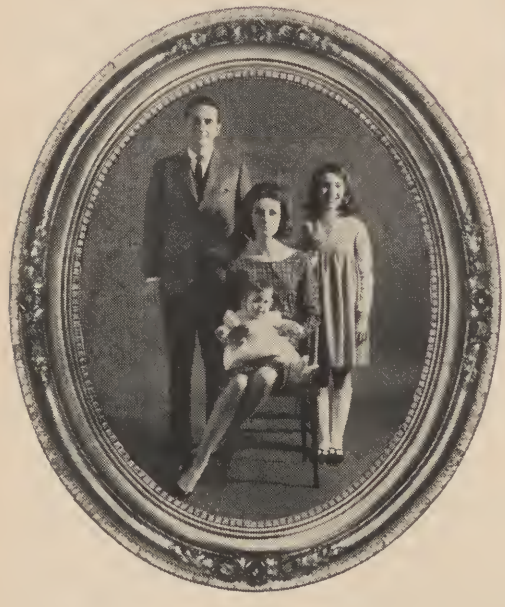
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.

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TELEVISION *as a Teaching Medium in Surgical Education*

HAROLD A. THOMAS, BS
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Television has proved to be an effective aid in teaching. Educators have explored its potential and adapted it to their peculiar needs. Wider acceptance and greater use is predicted. Recent developments in electronics and optics promise an exciting future for the medium. Medical pedagogy has as its goal the efficient training of physicians and surgeons, ultimately insuring better medical care. By contributing to the attainment of this goal, television has benefited all mankind.

HISTORICAL BACKGROUND

TELEVISION, A LABORATORY CURIOSITY in its infancy, was recognized by progressive educators as having inherent potential as a teaching medium. As early as 1931, the State University of Iowa began pioneering work in educational television.[1] These experiments, covering basic principles, laid the groundwork for further experimentation in the new field.

Medical educators soon realized that television could become a valuable tool. There are many difficulties in satisfactorily presenting living surgical demonstrations. As television would eliminate many of these difficulties, it was only natural that its first application would be in the field of surgery. In February, 1947, the Johns Hopkins Hospital demonstrated surgical operating techniques through the medium of television for the first time.[2] Five operations were presented over a closed circuit system consisting of two cameras and 10 receivers. Although the presentation was relatively crude and the program was in black and white, it was considered successful.

It was soon seen that black and white television was inadequate. If television was to become useful in medical education, an efficient color system would have to be developed. A pharmaceutical manufacturing company, in cooperation with medical consultants, began research on this problem, and the first program of operations on color television was presented at the annual session of the American Medical Association in 1949.[3] Although many technical difficulties were evident and production techniques were poor, the demonstration excited the imagination and interest of the medical profession and showed great unexplored possibilities in the new medium.

DEVELOPMENT

Surgical television has come a long way since. Programming and production have been refined and polished. Equipment has undergone a dramatic evolution as instrumentation and procedures have been developed for special needs. Television has not changed basic teaching techniques but has increased their versatility.[4]

As the field became complex, trained technicians were needed. Particularly in demand were specialists to coordinate the various aspects of program

This article was originally prepared as a term paper in a graduate program in education at Loyola College, Baltimore.

production. In some medical schools affiliated with universities having educational television facilities, it was possible to use available personnel.[5] Others developed the talents of existing personnel to adapt to the new situation. Still others had to secure technicians from industry.[6]

Today's performance must be flawless. No smallest detail can be overlooked in the planning, for there is no opportunity for "retakes" in this type of show. Training and rehearsal of surgeon-instructors is essential for the satisfactory presentation of their material.[5] Other operating room personnel also need rehearsal and may have to modify their procedures.[7] Should graphic materials, such as drawings or charts, be required, their preparation needs special attention.[8] Every member of the staff must realize the importance of his contribution and should be willing to cooperate fully with the others. There is no room for artistic temperament.

Earlier surgical television used standard commercial apparatus for taking, controlling, and receiving the program. Such basic equipment as this, sometimes modified to meet special needs, is now used in many institutions here and abroad.[9–11] It is satisfactory for most routine teaching assignments and avoids the expense of custombuilt equipment.

Some highly complex surgical techniques, such as endoscopy, have required the engineering of special electronic instruments. Formerly, the small size of the field and the limitations of instruments allowed only one person to observe and operate. Recent developments have linked optical design and electronics to enlarge the circle of observers.[12] Berci has developed a small, precise television camera for endoscopy.[13] The recently developed glass fiber bundles, which can carry light around corners, promise greater flexibility and versatility.[14]

Microsurgery has revolutionized treatment of the inner ear and other small structures. Again, only one or two observers could see the field until television expanded and magnified the view to make teaching in this area more effective.[15] A visual gap exists between the microscopic field and that viewed with the unaided eye. Structures in this "metascopic zone" are too large to view with the microscope and too small to be seen unaided. This zone can also be effectively explored and presented by television.[16]

Serial radiography is often employed in following the operative course, particularly during orthopedic and biliary surgery. Roentgen television has eliminated the delay incurred by the processing of conventional x-rays.[17,18] The primary purpose is to save time and minimize the surgical risk. In addition, such continuous radiologic observation during the setting of a fracture or exploration for gallstones provides an ideal teaching set-up.

These special applications of medical television benefit both the surgeon and the patient. Their secondary use as an educational medium benefits the student in two ways. First, he is better able to follow the delicate, precise surgery presented and, second, he is acquainted with the most modern equipment available.

ACCEPTANCE AND PRESENT USE

Television has had a tremendous effect on American society.[19] It is evident that educators could not ignore the influence that television has had on American thought. Students have been conditioned to regard television as a pleasurable medium, so it is not surprising that they are receptive to televised instruction. Studies on the effect of television on the learning process have shown that the student learns as well with television as he does with other modes of instruction.[20,21]

Educational television, as a demanding technique, presents a distinct challenge to the instructor.[22] Some educators view it as a definite threat to their position and have resented the intrusion of the new medium.[23] Speaking of medical applications, Ruhe[24] states:

> My own impression is that the greatest obstacle to the use of television is in the surgeons themselves, and their unwillingness to define many of the opportunities for teaching and learning which television in fact brings to them.

It is paradoxical that so many instructors reject the very medium which has been shown to be effective and acceptable to the student.

Despite the objections of some medical teachers, television has won acceptance as a teaching tool. In 1959 it was reported that 16 of the 65 medical schools in the United States had television installations.[25] Undoubtedly the number of installations has since increased. Tremendous initial expenditures testify to the great faith in the teaching value of television held by some educators and administrators.

Government agencies have sponsored a great deal of research and development in educational television as applied to medicine. The Army has established a television division at Walter Reed

Army Medical Center for training and education of medical personnel.[26,27] Color television has been used to present a postgraduate workshop on operating room nursing to military nurses.[28] The National Institutes of Health also has an active television developmental program.[29] This interest and work has helped to advance our concepts of television as a teaching medium. It is doubtful that such large scale research could be carried on by a private institution or organization.

Medical television is being used in teaching institutions throughout the world. In England, the Association for the Study of Medical Education is collecting information on the effective use of television in the curriculum.[30] Russian applications of television as a teaching tool seem to be mostly in surgery.[31] Germany, a nation of scientific and engineering accomplishments, has expressed interest in the medium.[11] In France, large medical teaching centers have developed television and are using it regularly.[32–34] Berci, in Australia, has done considerable research and developmental work on television as a teaching aid.[35] The Japanese, with their new optical and electronic centers, are also using educational television in their medical centers.[36] This worldwide interest and experimentation helps to provide better trained physicians and surgeons, thus insuring better medical care for all.

Television has become an integral part of medical education. In undergraduate education, opposition is heard from those who are opposed to teaching through "mass" media and regard learning as an individual process.[37] It is claimed that television, as it exists today, is better adapted to postdoctoral education than to undergraduate medical teaching.[22,37] Its effectiveness in refresher courses was demonstrated by a closed-circuit series of "Telecolor Clinics," seen by 30,000 physicians in eight towns.[38] One survey showed that most of the doctors interviewed preferred televised clinics to other forms of postgraduate demonstrations.[39] One authority enthusiastically looks forward to seeing a network of "scrambled image" television centers presenting the latest techniques to the busy practitioner.[40]

ADVANTAGES

Television offers many advantages over conventional methods of teaching surgery. The student has an unrestricted view of the operative field. His vision enters the incision with the surgeon's fingertips.[37] Delicate structures and precise techniques are magnified. Unencumbered by mask and gown or by the consciousness of being in the way, he is better able to relax and concentrate on the procedure being presented. Although physically isolated, he has a sense of being there to a degree never attainable from the conventional observers' gallery.[41,42] Versatility of the medium helps correlate other significant data with the surgical procedure, giving a well rounded, overall picture.[43] The size of the audience is practically unlimited, as networks and videotapes can be used.[37,43] In this manner, the student is able to see more unusual cases or operations than he would otherwise, and more effective use is made of the talents of the best instructors.

Removal of students from the operating room means that the staff can work more efficiently without interference, and the surgeon is freed of distraction. As an incidental advantage, the patient is better protected from the possibility of an airborne infection when the number of persons present is reduced.

Many of the educational advantages depend upon proper use of the teaching medium. Improper or careless use can negate any possible gains in the learning process.

DISADVANTAGES

A prime disadvantage of television is the loss of a close teacher-student relationship.[30] In addition, many instructors feel that they are mere performers and that the medium has control.[22,43] Modifications of teaching methods with an understanding and acceptance of television could reduce these problems considerably.

The tremendous cost of even a modest color television system is a great drawback. Structural design in anticipation of its use will have to incorporate expensive features in new hospitals and medical schools.[44] Both equipment and maintenance are costly.[37] Engineering personnel must be employed to operate and repair this complex electronic system. Although Ruhe[37] attempts to justify the cost and predicts that television may become economically indispensible, nevertheless, it seems that cost looms as a barrier to widespread acceptance.

Surgical technique, primarily dependent on manual dexterity, requires a fine tactile sense which cannot be transmitted by the medium. Although the instructors' comments are invaluable, they may not always be able to communicate the impressions formed by a combination of sensory perceptions



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and experience; but this criticism is not insurmountable, since it can be remedied by supplemental modes of instruction.

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REFERENCES

1. Lewis, L. L. (ed): *RCA Educ TV News* 42:1, 1960.
2. Trimble, I. R., and Reese, F. M.: *Bull Johns Hopkins Hosp* 81:186, 1947.
3. Elsom, K. A., and Roll, G. F.: *JAMA* 147:1550, 1951.
4. Schmidt, P. C.: *Trans Amer Acad Ophthal Otolaryng* 59:547, 1955.
5. Schumacher, H. J.: Univ Mich Med Bull 27:305, 1961.
6. Schafer, P. W.: JAMA 152:78, 1953.
7. McConnell, M.: *Amer J Nurs* 50:277, 1950.
8. Hodge, G. P., and Coates, T. B.: *Univ Mich Med Bull* 27:311, 1961.
9. Pazilauskas, V. F.; Dryer, B. V.; and Ruhe, D. S.: *J Med Educ* 26:1, 1951.
10. Karavinov, A., and Revis, V.: *Khirurgiia (Moskva)* 37:128,1961.
11. Meisner, R.: *Munchen Med Wschr* 99:1429, 1957.
12. Ruhe, D. S., and Gentry, K. C.: *J Kansas Med Soc* 62:49, 1961.
13. Berci, G., and Davids, J.: *Brit Med J* 5292:1610, 1962.
14. Ruhe, D. S.: *Sonderdruck aus Research Film* 4:95, 1961.
15. Kopac, M. J., and Harris, J.: *Ann NY Acad Sci* 97:331, 1962.
16. Guis J. A.: *Amer J Surg* 104:296,1962.
17. Lindblom, K.: *Acta Radiol (Stockholm)* 53:367, 1960.
18. Mallet-Guy, P.: *Surg Gynec Obstet* 106:747, 1958.
19. Coffin, T. E.: *Amer Psychol* 10:630, 1955.
20. Brown, J. W.; Lewis, R. B.; and Harcleroad, F. F.: *A. V. Instruction: Materials and Methods.* New York: McGraw-Hill, 1959.
21. Greenhill, L. P.: *Med Biol Illus* 11:239, 1961.
22. Brown, M. C.: *New York J Med* 60:869, 1960.
23. Lewis, L. L. (ed): *RCA Educ TV News* 61:1, 1962.
24. Ruhe, D. S.: Personal communication.
25. Council on Medical Television *Newsletter,* Autumn 1959.
26. Gorey, A. L.: *Med Bull US Army Europe* 13:152, 1956.
27. Bloom, R. R.: *US Armed Forces Med J* 9:180, 1958.
28. Phillips, K. W.: *Amer J. Nurs* 56:162, 1956.
29. Brown, M. C.: *World Med J* 9:99, 1962.
30. Fox, T. F. (ed): *Lancet* 280:1102, 1961.
31. Gorshkov, S. Z.: *Khirurgiia (Moskva)* 37:119, 1956.
32. Ory, A.: *Presse Med* 56:615, 1948.
33. Lafay, F.: *Presse Med* 66:1901, 1958.
34. Binet, L.: *Presse Med* 70:603, 1962.
35. Berci, G.: *Med J. Aust* 48:1005, 1961.
36. Sasaki, Y.: *Nat Def Med J (Tokyo)* 9:424, 1962.
37. Ruhe, D. S.: *World Med J* 9:102, 1962.
38. Holleb, A. I., and Buch, F. B.: *JAMA* 156:298, 1954.
39. Warner, R. S., and Bowers, J. Z.: *J Med Educ* 29: 27, 1954.
40. Warren, F. Z.: *J Med Educ* 31:413, 1956.
41. Carroll, W. W.: *Quart Bull Northwest Univ Med Sch* 23:204, 1949.
42. Towsley, H. A.: *Univ Mich Med Bull* 27:303, 1961.
43. Judge, R. D.: *Univ Mich Med Bull* 27:342, 1961.
44. Brown, M. C., and Blair, L.: *Rev Med Int Photo Cinema Telev* 1:2, 1962.

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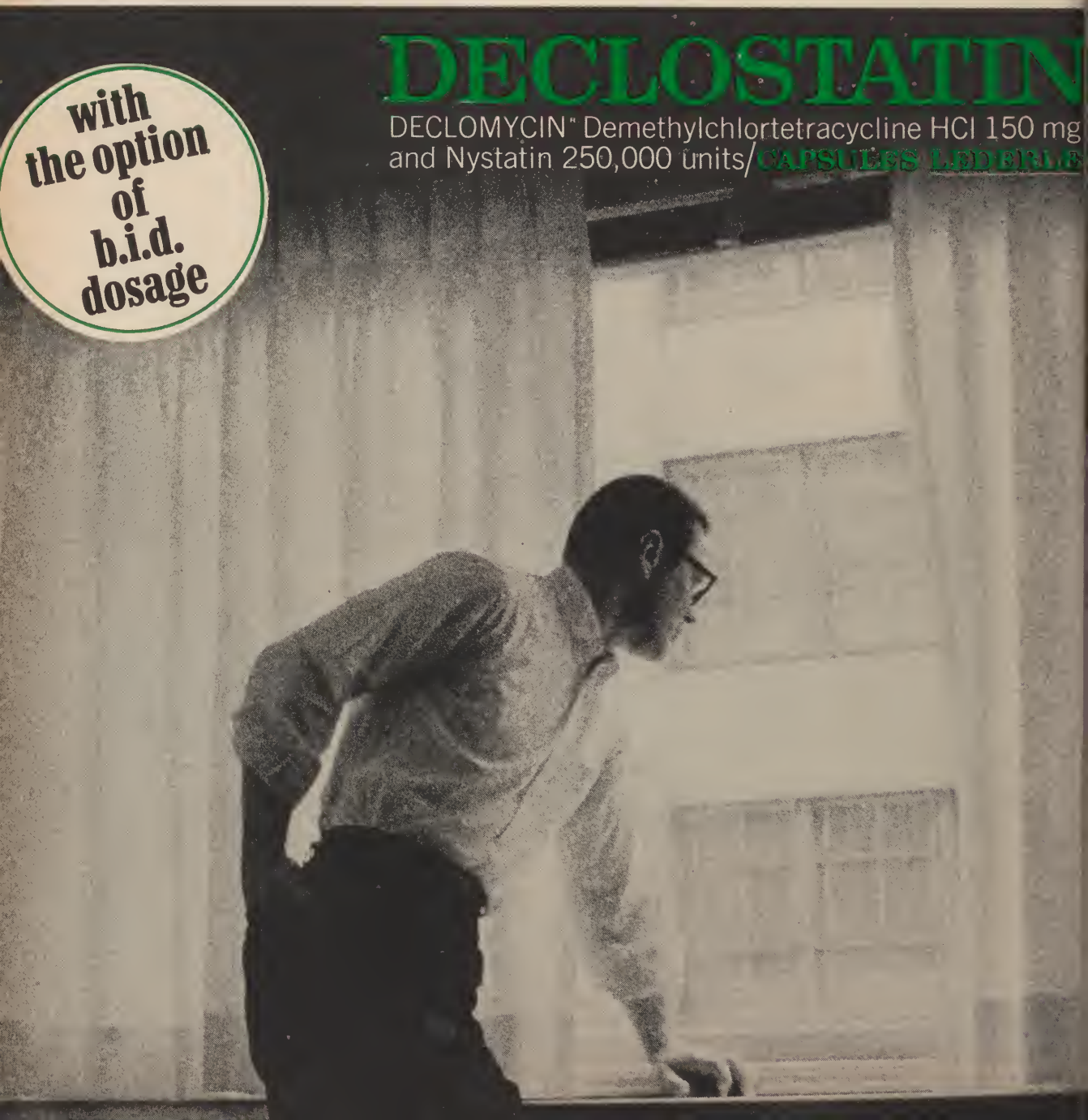
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Medicine in Tropical Africa

DANIEL H. CONNOR, MD
Geographic Pathology Division
Armed Forces Institute of Pathology

WESTERN MAN'S PENETRATION of central Africa began more than 100 years ago, when the early explorers, constantly at grips with fevers, exhaustion, and native porters, trekked thousands of miles inland from the east and west coasts. Missionaries, teachers, physicians, soldiers, engineers, artisans, merchants, and trappings of civilization soon followed. Although some tribes have shunned contact and remain unchanged, the great mass of black Africa has been steadily drawn toward Western ways. These efforts have culminated in the emergence, during the past 10 years, of no less than 33* newly independent African states; and these states stand anxious, if not quite ready, to take their place in the world community. Today there is more interest than ever in the medical and public health problems of tropical Africa.

A system of recording vital statistics, including reporting of deaths, is not yet established in tropical Africa; but insight into death trends can be gained from autopsied cases. From these small and selected samples consistent patterns emerge. In Kampala, Uganda, for instance, accidents and violence account for no less than one quarter of the total autopsies. Roadway trauma, gunshot wounds, knife wounds, drownings, and fire contribute to this amazing total; and alcoholism is a predisposing factor in many of these cases.

A second group of diseases important in Africa comprises those conditions that have come under increasing control in the United States. Some of these are tuberculosis, typhoid fever, intestinal parasitism (including hookworm disease and amebiasis), lobar pneumonia, tetanus, suppurative meningitis, and the complications of pregnancy and parturition. All of these cause many fatalities, but tuberculosis is the biggest single killer of all. This is true not only in Africa but also in the developing countries of other continents.

A third group comprises diseases common to both developed and underdeveloped countries. Organic heart diseases, chronic cardiovascular renal diseases, malignant tumors, diabetes mellitus, infectious viral hepatitis, bacillary enteritis, and cirrhosis fall into this group.

Fourth are those diseases peculiar to the tropics which are rarely seen in the United States. These are malaria, schistosomiasis, leprosy, onchocerciasis, bancroftian filariasis, trypanosomiasis, and malnutrition (including starvation and kwashiorkor).

A fifth group deserves special mention, for from the research point of view it is most interesting of all. These are the "new" diseases of Africa, recognized during the past 20 years. These diseases add much to our knowledge of man's reaction to his environment and as such deserve our attention. Four of these are mentioned here.

African histoplasmosis was discovered in 1956. It is a fungus infection of man caused by *Histoplasma duboisii*. The infection may be localized, usually to skin or bone, in which case there is a tendency to spontaneous resolution; or it may be disseminated and fatal with multiple organs involved. In culture *H duboisii* is very similar to

EDITOR'S NOTE: Our proximity to the Armed Forces Institute of Pathology is indeed fortunate, a point substantiated by this unusual and interesting paper by a member of their Geographic Pathology Division. *M.J.R.*

*There were four independent African states in 1955—Egypt, Liberia, Ethiopia, and the Union of South Africa. The total is now 37.

Histoplasma capsulatum, but in tissue sections *H capsulatum* is noticeably smaller. The 56 known cases have come from western and central Africa, between the two great deserts, Sahara and Kalahari.

A second fascinating new disease of equatorial Africa is the Burkitt tumor, named after Mr. Denis Burkitt (British surgeons are called mister), a staff surgeon at Mulago Hospital in Uganda. Recently this disease has generated widespread interest. The clinical features were first described in 1958, and the ensuing reports by Mr. Burkitt and his colleagues have revealed an exciting story of step by step detective work in geographic pathology. The tumor is a lymphosarcoma of peculiar cell type intermingled with occasional large, pale phagocytic cells, giving the so-called starry sky pattern. Although seen in other parts of the world, this tumor syndrome was recognized and defined in Africa, where the incidence among children is exceedingly high. It involves the jaws, kidneys, and gonads most frequently, but strangely, it does not usually involve the lymph nodes nor does it become leukemic. Untreated, it is rapidly fatal. The most challenging aspect of the syndrome, however, is its geographic distribution. Observation has revealed high incidence across tropical Africa except in those areas above 5,000 feet. South of the equator the disease persists only in those areas where the temperature remains above 60°. Observations in West Africa have shown a marked decrease in incidence in areas where the annual rainfall is below 30 inches. The conclusions that the high incidence is moisture dependent, and altitude dependent because it is temperature dependent, seem justified from these observations. Mr. Burkitt has hypothesized that this tumor is caused by an arthropod-borne virus.

A third new disease of Africa is endomyocardial fibrosis. This acquired, progressive, fatal heart disease attacks children and young adults and manifests itself clinically by chronic right- and

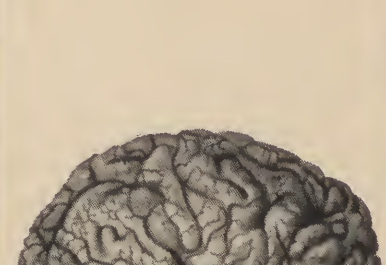
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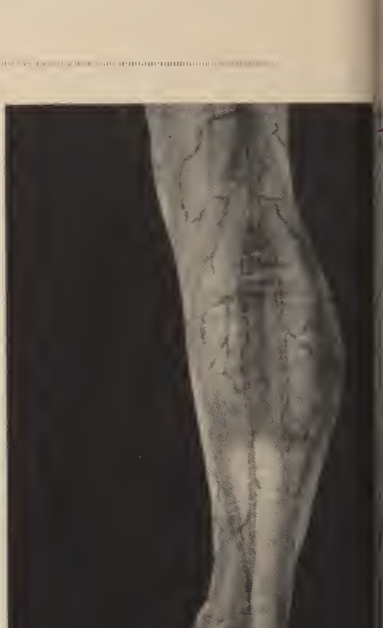
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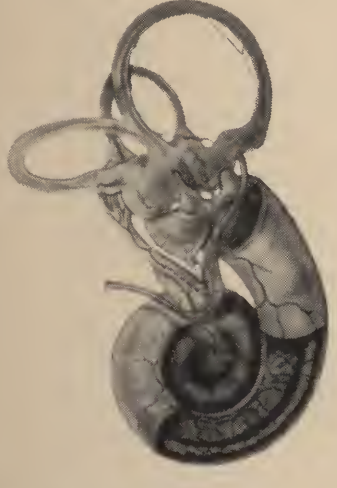
where ischemia causes pain, spasm, ache, intermittent claudication; also coldness, numbness or ulcerati of extremities.

left-sided congestive failure. It was first defined at autopsy by Professor J. N. P. Davies. The mural endocardium is thickened by thrombosis and scar tissue, and the underlying myocardium is also scarred. Although this disease is prevalent in one tribal group and rare in others, it has been reported from both East and West Africa. In spite of careful clinical and pathologic studies, no clues to the cause have yet been discovered.

The fourth new disease from Africa is necrotizing skin ulceration caused by *Mycobacterium ulcerans*. This was recognized as a unique and rare disease in Australia, but in some parts of central Africa it is, because of its prevalence, a major public health problem. In some cases progressive skin loss necessitates amputation of the affected extremity. The causative organism looks and stains like the tubercle bacillus, but, peculiarly, it grows best at 33° C, it causes a selective necrosis of subcutaneous adipose tissue, and it proliferates to form colonies in the necrotic tissues. These features are reminiscent of a saprophyte, and—in the same line of thought— this disease has some features in common with *Clostridium welchii* infections. If studies reveal a diffusing toxin from *M ulcerans*, a new field in mycobacterial research will be open. In the meantime, *M ulcerans* ulceration has joined leprosy and tuberculosis as an important endemic mycobacterial disease in Africa.

The increased interest in African medical problems stimulated by World War II has continued apace and has given us knowledge of the endemic problems as well as bringing to light these new diseases. We should remember that these entities were recognized by men who first were familiar with the medical problems in their own territories and who in their spare time and with a few shillings for research have given us much to think about.

Many fascinating research problems await the clinician, microbiologist, pathologist, parasitologist, epidemiologist, and entomologist in tropical Africa.



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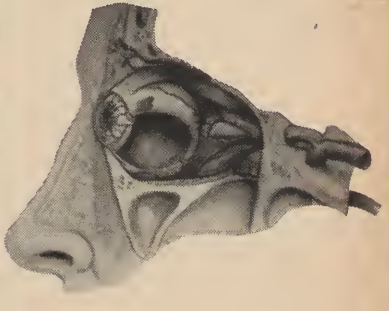
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Current studies suggest that dietary inadequacies of calcium of many years duration may contribute to the development of osteoporosis in later life. Osteoporosis has been found to occur much more frequently in elderly patients who have become accustomed to a low calcium intake than in those with a high level of calcium consumption. Metabolic, histologic and radioactive tracer turnover studies have demonstrated that increased bone resorption due to a deficiency of calcium in the metabolic pool is a prominent feature of human osteoporosis.

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The Heart Page

Ralph Weber, MD—*Editor*

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HYPERTHYROIDISM AND HEART DISEASE

STUART H. BRAGER, MD

THE RATE OF PRODUCTION and peripheral utilization of thyroid hormone has a direct and profound effect on almost all organs, including the heart. Thyroid hormone causes an increase in oxygen consumption by the cardiac muscle; work is accelerated; glycogen stores are depleted. Other less understood mechanisms at a mitochondrial level no doubt occur. In addition, the heart is required to meet the demands of a generalized metabolic speed-up throughout the body.

Investigators disagree whether or not there is any true hyperthyroid heart disease. One group argue that hyperthyroidism produces clinical cardiac findings only when coincident organic heart disease such as atherosclerotic, rheumatic, luetic, or hypertensive changes are noted. In support of this philosophy is the peak age of 40 plus years found in thyrocardiacs, as opposed to the 20-40 year peak for all hyperthyroids. Autopsy series in the literature report ranges of 50-99% coexistent hyperthyroid and organic heart disease. Microscopic changes found in hyperthyroid hearts of round cell infiltrates, necrosis, and interstitial fibrosis are also described in ischemic heart disease.

The second group concede that many patients with hyperthyroidism have pre-existing cardiac disabilities which contribute to the final picture but maintain that the excessive demands made on the heart by hyperthyroidism are sufficient in themselves to produce cardiac enlargement, congestive failure, or arrhythmias. They cite the apparent return to a normal cardiovascular status following the achievement of euthyroidism in many of their patients. Animal studies have attempted to prove a decreased myocardial efficiency in the presence of added thyroid hormones. These studies are not entirely conclusive.

This paper will not attempt to take sides in this controversy. There is no great point to decide, and the deliberation is one which does credit to the Sophists. The crux of the matter is that hyperthyroidism, whether as the prime cause or as an aggravating or precipitating factor, plays a critical role in the production of severe cardiac abnormalities.

The fundamental problem in the thyrocardiac patient is the need for a marked increase in cardiac output and the stress which this need imposes on cardiac reserves. High outputs are generally maintained with little increase in stroke volume but with a significant rise in heart rate. Increased cardiac output may occur in hyperthyroidism without hypertrophy if the stroke volume and therefore the diastolic tension are not increased. The increased cardiac output is required to meet demands for more oxygen by the tissues and to dissipate the excess heat produced by these oxidative processes. Peripheral resistance falls as arteriovenous shunts are opened, especially in the skin. The systolic blood pressure rises without appreciable rise in diastolic pressure (unless cardiac failure ensues). The increased venous return is handled to a small extent by an expanded blood volume but mostly by a markedly decreased circulatory time.

As cardiac work increases, cardiac oxygen consumption must necessarily go up. No appreciable change in the arteriovenous oxygen difference occurs across the coronary circulation. Therefore, this oxygen demand must be satisfied by an augmented blood flow through the coronaries. When this demand no longer can be met, the cardiac response is enlargement, ischemia, arrhythmia, and finally failure.

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Up to this point, we have dealt in terms of the pathophysiology of thyrocardiac disease. Of equal importance are the varied clinical manifestations and their prompt recognition. If the patient presents with the classic symptoms of thyrotoxicosis and, in addition, has atrial fibrillation or congestive failure, the diagnostic problems are not great. When the cardiac findings are the predominant ones and the classic exophthalmus, goiter, tremor, warm and moist skin are obscure, then the physician's acumen is taxed. "Masked hyperthyroidism" is the term used to describe the latter condition. It must be suspected when atrial fibrillation, especially of the paroxysmal type, is found. It must be sought when cardiac failure or tachycardia or both occur without obvious cause and especially when they do not respond in the usual way to digitalis, diuretics, and bed rest. One cannot expect to adequately control the cardiovascular symptoms until the hyperthyroidism has been vanquished.

A sometimes difficult but fortunately rare trap is posed by the similarity of hyperthyroidism and mitral stenosis. In both instances, a loud snapping first sound may be heard at the apex, atrial fibrillation is noted, a murmur is detected, and a prominent pulmonary artery may be seen. The differentiation can be made if the physician remains aware of this situation.

Treatment can only be mentioned briefly. Subtotal thyroidectomy should be reserved only for the rare cases of tracheal compression. Radioiodine therapy is the method of choice and may be combined with antithyroid drugs if one fears an exacerbation in the immediate posttreatment period. We have not had any unmanageable problems after the administration of I^{131} to patients with congestive failure and thyrotoxicosis. Improvement of the cardiac condition uniformly was noted with the patient's return to a euthyroid state. Digitalis, diuretics, and salt restriction may still be required in the face of residual unassociated organic heart disease. Quinidine therapy or cardioversion may be attempted in those patients with persistent atrial fibrillation.

In summary, whether or not hyperthyroidism produces a separate and distinct type of heart disease, its prompt recognition and adequate treatment is of paramount importance in maintaining proper cardiovascular function.



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Drug-Induced Ulcerations of the Small Intestine Associated With Acute Abdominal Symptoms

MARTIN W. DONNER, MD
R. PATTERSON RUSSELL, MD
MARTIN L. SILBIGER, MD

ACUTE NONSPECIFIC ULCERATIONS of the small intestine were rarely reported before 1963.[1] These lesions, pathologically distinct from ulcerations of regional enteritis, tuberculosis, or lymphosarcoma, resemble peptic ulcers occurring elsewhere in the gastrointestinal tract.

The increasing frequency of small intestinal ulceration of unknown cause, usually presenting with symptoms of obstruction, was first reported in Sweden in 1964.[2] The authors reviewed the history of 20 patients and strongly suspected thiazide diuretics or potassium chloride medication or both as the agents responsible for stenosing ulcers of the small bowel. Shortly thereafter, 12 cases occurring within 15 months were reported in America.[3] The ulcers were associated with small bowel obstruction and in two instances with perforation. All patients had cardiovascular disease and all but one had received some form of enteric coated potassium chloride. An extensive survey was initiated by two pharmaceutical companies, who reviewed the reports of 488 hospitals.[4] In 56.8% of 484 patients with small bowel ulcers, diuretics or potassium chloride had been administered. Moreover, one of us (RPR) knows of 129 cases from Sweden, Brooklyn, Los Angeles, Minneapolis, Baltimore, Norfolk, and Daytona Beach, all areas where an extensive and exhaustive review of the patients' drug histories had been performed.[5] It was found that 95% of these patients had received potassium chloride in an enteric coated form and, of this group, 97% had been given an enteric coated thiazide diuretic in combination with potassium chloride. In the Baltimore area alone, 14 instances of small intestinal ulceration have been observed; 11 of these patients had been treated with this drug combination; in two cases a detailed drug history could not be obtained.

Clinical data revealed that most of the patients under investigation had received the drug combination because of hypertension or congestive heart failure. Symptoms consisted of recurrent crampy periumbilical discomfort, nausea, vomiting, and intermittent abdominal distention. Intestinal obstruction was the most common finding; perforation occurred in about 25%, while bleeding was infrequent. Slightly less than 30% had had previous abdominal surgery. Although single ulceration is found most frequently, there may be two or more ulcers of the distal jejunum or ileum. The duration of treatment with enteric coated preparations containing potassium chloride prior to the development of symptoms varied from several days to three years.

Several clinics have found a 2-3% incidence of ulceration of the small intestine in outpatients given enteric coated thiazides with potassium chloride for the treatment of hypertension or congestive heart failure or both. Outpatients from the same clinic treated with thiazide diuretics alone for similar underlying conditions had no small intestinal ulceration (see table).

A representative history is as follows (Fig. 1). A 30-year-old white housewife with recently evalu-

From the Departments of Radiology and Medicine, The Johns Hopkins University and Hospital.
This study was supported in part by Merck, Sharp, and Dohme.



Fig 1

Three-hour film of a small bowel series showing partial obstruction of distal ileum proximal to penetrating ulceration (inserted spot film). Relevant clinical history in text.



Fig 2

Undissolved enteric coated diuretic tablets containing potassium chloride visible on plain film of the abdomen. Patient was a 59-year-old retired construction worker with history of hypertensive arteriosclerotic cardiovascular disease and congestive heart failure. Received treatment for six months and had crampy abdominal pain for six weeks before admission. At surgery a typical stenotic ulcerated segment excised from terminal ileum was found.

ated hypertension had been treated with enteric coated thiazide with supplementary potassium chloride for a period of six weeks. Symptoms had been present for one month in the form of crampy lower abdominal pain, nausea, and vomiting. Three days after the radiologic examination and discontinuation of all medication the symptoms became more severe and an acute abdominal condition developed, suggesting imminent perforation. At surgery one annular ulcer (see spot film, Fig. 1) on the verge of perforation and four superficial ulcers were found. Segmental resection and anastomosis of the involved loop of ileum were performed. Postoperative convalescence was uneventful.

Roentgenograms obtained during gastrointestinal examination usually show moderately distended loops of small intestine and stretching of mucosal folds characteristic of small intestinal obstruction (Figs 3 and 5). Such films will occasionally demonstrate the obstructive site, and one or more ulcer craters may be visible (Figs 4 and 5). Occasionally ulcerations will be seen when films are obtained in oblique or lateral positions or during fluoroscopic examination using compression devices and spot film techniques (Fig 1). The transit time of the barium meal may be delayed depending on the degree of intestinal obstruction. Plain films of the abdomen often show opaque tablets of potassium chloride in the region of the stomach or small intestine (Fig 2).

Typically, the pathologic appearance is that of a circumferential ulcer in the distal jejunum or ileum,





Fig 3 (above)

Same patient as in Fig 2. Small bowel obstruction demonstrable on film three and a half hours after barium meal.



Figs 4 and 5 (right)

Small intestinal series showing several ulcer craters in widely separated loops of ileum and low-grade obstruction, one half hour (Fig 4) and one hour (Fig 5) after barium meal. Patient was a 66-year-old laboratory technician with hypertensive arteriosclerotic cardiovascular disease. Received a thiazide diuretic supplemented with potassium chloride for 18 months and had intermittent crampy abdominal pain for five months before admission. See Fig 6 for excised surgical specimen.



Fig 6

Unopened specimen of terminal ileum containing three constricted areas in the same segment. Opened specimen revealed circumferential ulcers underlying each area of constriction. A fourth, more superficial ulcer, was demonstrated on microscopic examination.

varying in diameter from several millimeters to more than 4 cm, and averaging 1.5 cm. Many ulcers tend to overlie a narrowed segment with characteristic submucosal fibrosis. While solitary ulcers are the rule, as many as five ulcers have been found in some patients. The ulcer craters are usually sharply delineated, and normal bowel mucosa is seen immediately adjacent to them. The supplying vessels may appear sclerotic without evidence of narrowing or obstruction.

After reports of ileal ulceration in patients treated with oral diuretic tablets containing potassium chloride, studies have been conducted in monkeys and dogs in an attempt to reproduce the lesions.[6–8] Enteric coated potassium chloride tablets of 500 to 1,000 mg have produced small intestinal lesions ranging from craters to perforated ulcerations in both species. Syrup of potassium chloride (5%) or rapidly disintegrating tablets have caused gastric ulcerations in monkeys. Enteric coated placebo tablets and thiazides alone did not produce any lesions in the gastrointestinal tract.

CONCLUSION

Small intestinal obstruction and perforation in patients under treatment for hypertension or congestive heart failure may be produced by stenosing ulcers as a result of the direct action of enteric coated potassium chloride alone or in combination with thiazide diuretics Radiologic studies can frequently localize the obstructive site and demonstrate the ulceration.

183 Hypertensive Patients Treated With or Without KCl

	Number of Patients	Small Bowel Ulcer
Thiazides alone	84	0
Thiazides and KCl		
Esidrix-K	68	2
Other	31	0

REFERENCES

1. Watson, M.R.: Primary Non-specific Ulceration of the Small Bowel, *Arch Surg* 87:600-603, 1963.
2. Lindhomer, B.; Nyman, E.; and Ral, L.: Nonspecific Stenosing Ulcers of the Small Bowel, *Acta Surg Scand* 128:310-311, 1964.
3. Baker, D.R.; Schrader, W.H.; and Hitchcock, C.R.: Small Bowel Ulceration Apparently Associated with Thiazide Potassium Therapy, *JAMA* 190:586-590, (Nov) 1964.
4. Lawrason, F.D.; Alpert, E.; Mohr, F.L.; and McMahon, F.G.: Ulcerative Obstructive Lesions of the Small Intestine, *JAMA* 191:641-644 (Feb) 1965.
5. Russell, R.P.; Carliner, N.; Yardley, J.H.; and Donner, M.W.: Small Bowel Ulceration and Stenosis Associated with Enteric Coated Preparations Containing Potassium Chloride, in preparation.
6. Diener, R.M.; Shoffstall, D.H.; and Earl, A.E.: The Production of Potassium-induced Gastrointestinal Lesions in Monkeys, *Fed Proc* 24:714, 1965.
7. Bokelman, D.; Bagdon, W.; Zwickey, R.E.; and Mattis, P.A.: Ulcerogenic Effect of KCl on the Gastrointestinal Tract of the Monkey, *Fed Proc* 24: 715, 1965.
8. Boley, S.J., et al: Experimental Small Bowel Ulceration, *JAMA* 192:763-768 (May 31) 1965.

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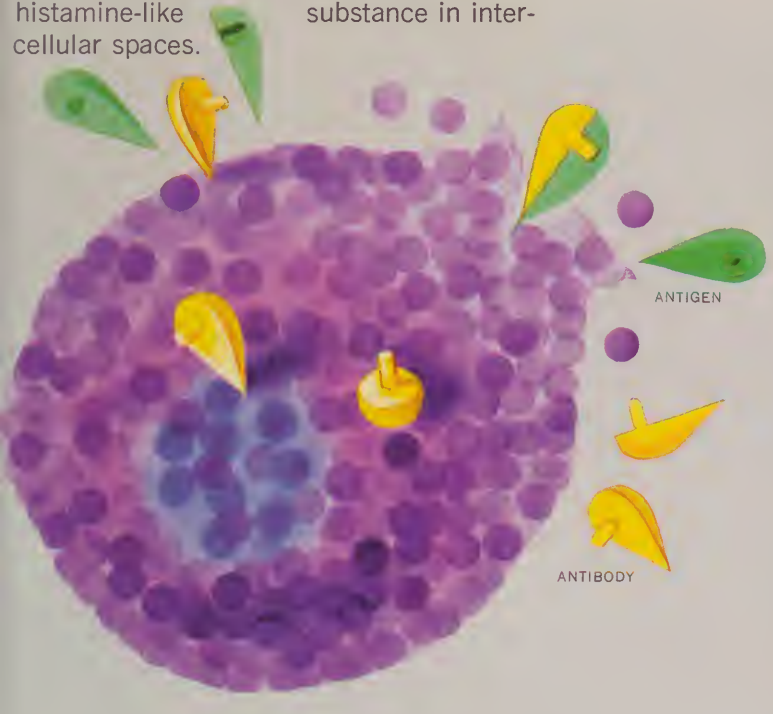
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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

New Directory for Physicians Treating Alcoholic Patients

A *Directory of Specialized Services for Alcoholics in Maryland,* published in June by the State Department of Mental Hygiene, is available free upon request to the Department's director of information services, Mrs. Cynthia Moore.

Listed with full information in the attractive 20-page pamphlet are the fellowships (AA, Al-Anon, and Alateen), seven area councils on alcoholism, 11 alcoholism clinics, four state hospital alcoholic rehabilitation units, 16 half-way houses, and three private rehabilitation centers. State resources for speakers, pamphlets, and professional training are included, as are also the five leading national organizations in the alcoholism field.

In the foreword, Isadore Tuerk, MD, commissioner of mental hygiene, expresses optimism without complacency about progress toward alcoholism control:

> Our specialized out-patient clinics, for example, are treating only about 400 of the state's estimated 80,000 alcoholics. There is in all the State outside Baltimore City only one half-way house for alcoholics. Only 50 percent of the State's general hospitals accept and treat alcoholics in the acute stage of their illness. Although our State recognizes alcoholism as a disease and not a crime, the only "service" for drunkenness offenders continues to be provided by police departments, courts, and correctional institutions, except for one therapeutic program in Prince George's County. And these are only four of many more inadequacies I could list.
>
> But I am optimistic for the future. I believe that we are moving against alcoholism now on many fronts, and that we shall continue to move even faster in the next five years. I know that we have valuable and distinguished allies to keep us in motion: the Governor and General Assembly of the Free State, the State Board of Health and Mental Hygiene, the Advisory Council on Mental Hygiene, the Medical and Chirurgical Faculty of Maryland, the Area Councils on Alcoholism, AA and Alanon members and groups, the dedicated staffs of our alcoholism clinics and State Hospital Alcoholic Rehabilitation Units, to mention only a few.

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REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Recent Advances in the Rehabilitation of Rheumatoid Arthritis

PHYSICAL EXAMINATION OF THE JOINTS

DESPITE THE INCREASED IMPORTANCE of laboratory methods in the clinical practice of medicine, the physical examination and history are not only holding their own but in a few instances are replacing elaborate diagnostic methods. Better understanding of the physiology of heart sounds and murmurs has led to important new information which can be obtained at the bedside.

No such new information has developed in the bedside examination in arthritis, but the publication of a book devoted entirely to the examination of the joints[1] has placed at the physician's disposal all the important information that can be obtained by purely clinical methods.

In most patients with rheumatic complaints, the physical examination is of crucial importance. The history, x-ray examination, and various blood tests generally only confirm a diagnosis made by physical examination. Furthermore, the physical changes in the joints with time present the most satisfactory way in which to follow patients with arthritis.

This book summarizes a long experience in rheumatology at the Mayo Clinic. The descriptions of techniques of examination, the correlation and summary of the medical literature, together with excellent diagrams, make it essential to every physician who deals with rheumatic diseases.

An introductory chapter classifies the different kinds of joints and describes the important physical signs in arthritis. The differentiation of intra-articular swelling from periarticular soft tissue inflammation is explained. Methods by which the synovial membrane may be palpated are described. The importance of localizing joint tenderness accurately is emphasized.

Various causes of loss of motion, such as spasm, fibrositic gelling, fusion, synovitis, locking of loose bodies, and fibrous proliferation are described, and methods and significance of distinguishing them are taken up.

Because of the nature of arthritis, it is particularly important to be able to record changes in the physical examination of the joints. A simple method is presented by which a full examination of each joint and the degree of swelling, tenderness, and limitation in motion can be recorded. This method can be used by any physician.

In later chapters individual joints are described. The findings on inspection, palpation, and motion follow. Each chapter has a short bibliography. The diagrams of the joints are particularly helpful. The arrangements of the chapters into anatomic descriptions of specific joints makes this book easy to use. Although the material presented is not strictly new, the book may be considered to have advanced the field of rheumatology.

PHYSICAL MEDICINE IN RHEUMATOID ARTHRITIS

In the discussion of recent developments in rehabilitation of rheumatoid arthritis, it is important to emphasize that the basic regimen is still most important as the beginning treatment for all patients with active rheumatoid arthritis.

The basic regimen consists of salicylates, heat, and rest interspersed with carefully controlled mobilization to maintain joint range of motion and muscular strength.

The use of heat, rest, and meticulous follow-up will be particularly emphasized in this column.

1. Relief of Pain

In addition to drugs, immobilization and heat are essential to the alleviation of pain during the acute stage of rheumatoid arthritis. Bedrest is helpful, but the patient should not be told just to go to bed. We have seen patients who took to bed early in their disease and never walked again. A definite program of daily exercise should be prescribed even when the patient is in bed.

Painful joints may be immobilized by the use of plaster casts with rapid improvement. Although it seems probable that with excellent physical therapy, full range of motion may be recovered after prolonged use of casts, most authorities prefer to use half splints with daily movement of the joints.[2]

Almost any type of heat will give temporary relief of pain in the involved joints, although many prefer hot packs and skin surface heat (infrared) to deep heat (diathermy and ultrasound).

A Hubbard tank is the best way to administer heat to the largest number of joints. The limbs, being supported by water, are easily moved by a therapist, thus helping maintain range of motion.

Heat to peripheral joints may be administered by a whirlpool bath. When the hands are involved, a paraffin bath several times daily is helpful.

2. Maintenance of Range of Motion and Muscular Strength

A. Position in Bed.—While the patient is immobilized in bed, during the period of acute rheumatoid arthritis, it is particularly important to give meticulous attention to bed position. A hard mattress and bed board will prevent hip flexion and shoulder adduction and internal rotation. Pillows under the head are to be avoided since they promote a tendency to dorsal kyphosis. When the patient sits up in bed, the head should be kept in alignment with the spine. While pillows under the knees relieve pain, they should be avoided because they promote both hip and knee flexion contractures. The feet should be protected from the weight of the sheets by a foot board.

Poor positioning in bed can cause irreparable damage in as little as two weeks. Lying on the stomach for several hours daily as the pain becomes less severe is a particularly helpful method of preventing hip and knee flexion contractures. The feet should be allowed to project over the end of the mattress so that foot-drop does not develop.

B. Range of Motion.—To maintain range of motion in rheumatoid arthritis, the patient must be involved and taught how to exercise alone at home. The most important factor in encouraging the patient to remain on the program is good rapport with the doctor and frequent follow-up visits. A complete explanation of the common deformities and how they may be prevented is essential. Directions to the patient must be simple, and only the most important joints should be worked with. A schedule of exercises written specifically for each patient and explained during practice under the supervision of a physical therapist is the best method of insuring continued performance.

C. Selective Muscle Strengthening.—Muscle atrophy, which is part of the disease, is made worse by disuse. Efforts should be made to maintain muscle strength, particularly in the muscles crossing the most important joints. Instructions for this program should be contained in the written program for maintenance of range of motion. The patient should understand why he is performing a specific exercise, how often it should be done, and exactly how to do it.

Particular care should be taken to maintain range of motion and strength in the following joints. The knee is the most important joint in which to maintain range of motion because once flexion and extension are lost in the knee, the patient is no longer able to ambulate and loses the range of motion in many other joints including the hip and to a lesser extent the arms.[3] Specific exercises for flexion and extension of both hips and knees are important, but if the patient can learn to sleep on his stomach, this position will tend to keep both knees and hips in extension.

In the upper extremities, abduction of the arm is lost early. The use of an overhead pulley with a rope and hand grip is an effective way to maintain range of motion. Precautions should be taken not to exercise the shoulders enough to cause persistent pain. In the forearm, supination and extension of the wrist are lost. Loss of abduction and extension of the thumb may greatly reduce the significant function of the hand with the formation of a "boutonniere" thumb deformity caused

by slippage of the extensors of the thumb to the ulnar side of the first metacarpal-phalangeal (M-P) joint. Ulnar deviation of the finger alone does not cause a great loss of function, but when combined with dislocation of the M-P joints, the formation of the "swan-neck" deformity may cause loss of power grip.

I believe that the major failure in the treatment of patients with rheumatoid arthritis is inadequate follow-up.[4] Prevention of contractures is the major long term goal. In addition to frequent office visits, the patient should be seen in the home by a physical therapist under the physician's direction. The local Chapter of the Arthritis Foundation may be able to put physicians in touch with physical therapists available for house visits.

The basic regimen of salicylates, heat, and maintenance of range of motion suffices to maintain comfort and range of motion in many patients with acute rheumatoid arthritis. It is unfortunate that these simple and harmless measures have been by-passed in favor of steroids in many patients.[5] It should be clearly understood that even when steroids are indicated, it may be necessary to continue the basic regimen as well.

REFERENCES

1. Beetham, W. P.; Polley, H. F.; Slocumb, C. H.; and Weaver, W. F.: Physical Examination of the Joints, W. B. Saunders Co., Phila. 1965.
2. Conference on Criteria For and Evaluation Of Orthopedic Measures in the Management of Deformities of Rheumatoid Arthritis. *Arthritis Rheum* 7:5, Part II (Oct.) 1964.
3. Tayler, D.: Deformity in Rheumatoid Arthritis. *Canad Med Ass J* 82:549, 1960.
4. Carroll, D.: Follow-Up in Chronic Diseases. *Maryland Med J* 14:59 (May) 1965.
5. Hollander, J. L.: The Calculated Risk of Arthritis Treatment. *Ann Intern Med* 62:1062, 1965.

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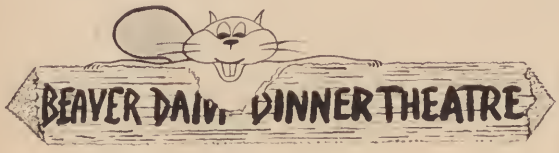
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Diagnosing the Battered Child Syndrome

THE BATTERED AND NEGLECTED child is not a product of our time, but increased awareness of the problem is evident by the numerous publications and meetings in the past 15 years. State legislatures have passed laws making reporting of cases mandatory by physicians, hospitals, and workers in allied fields. Maryland law requires physicians to report evidence of mistreatment of children to the Maryland State Police or the county or city police department. The law relieves physicians from liability in reporting the case and the judicial proceedings which may result.

Physical abuse of children is increasing, and physicians in practically all specialties may see such cases. The examining physician should suspect the "Battered Child Syndrome" when the history is inappropriate to his findings, such as unexplained malnutrition, bizarre purpura, and fractures and other injuries, particularly in infants and children under three years. Most parents will not confess to the physician but will deny any knowledge of willful trauma. Parents may describe frequently occurring accidents, such as falling from bed or down a step, or a sibling may be implicated. The cases that come to the attention of the community are extreme ones that are obvious, but there are many other cases in which there is legitimate suspicion of abuse but no clear proof. Implicated parents or guardians usually seek medical care from a different source for each new physical injury in order to avoid suspicion.

The radiologist may be the first to make the diagnosis by finding additional or "surprise" injuries. The lesions found on x-rays are multiple fractures in different stages of healing, epiphyseal injuries, long bone periosteal proliferation, and metaphyseal corner fractures (according to Caffey the latter occur in no other condition).

An injury witnessed by only one person should make the physician suspicious. In addition to performing a careful examination, he should consider x-raying the head, ribs, and long bones. Trauma attributed to hot liquids, accidental poisoning, and accident prone infants may be part of the picture of child abuse. Subdural hematoma continues to be the most frequent finding associated with internal injuries. Deliberate injury must be excluded as the etiology in all subdural hematomas.

Although not the slightest question exists about physicians' responsibility toward the child who needs protection from occult neglect or overt abuse, we also should hold in mind our responsibility to the parents. A nonjudgmental attitude, concerned *only* with the patient's health and future, needs to be maintained toward the parents whose innocence or guilt is a matter for the courts. Severe family disruptions and serious consequences *can* occur and *have* occurred as a result of overly enthusiastic application of the good principles of this article directed to the best interests of children.

". . . but let us judge not, that we be not judged."

(Lincoln's 2nd Inaugural Address, March 4, 1865)

KARL GREEN, MD

The high incidence of subdurals may be partly due to the head's being unprotected, since infants are usually wrapped in clothes or blankets.

The Battered Child Syndrome is a significant cause of permanent disability and death. Unfortunately, it continues to be misdiagnosed, not recognized, or, if diagnosed, not referred to the proper authorities. Radiologically the Battered Child Syndrome may be mistaken for atypical scurvy, syphilis, osteogenesis imperfecta, or infantile cortical hyperostosis. These may be considered because of the physician's reluctance to accept the true implications of the lesions in the skeleton.

Radiological findings of injury to the growing bones of the abused child are the same regardless of history. To the informed physician, the x-ray films tell the story that the child is too young or too frightened to tell.

Abuse occurs not only by parents or guardians with psychopathic personalities or of borderline socioeconomic status, but also in families with good education, stable finances, and adequate social background. These attacking parents may be impulsive, self-centered, hypersensitive, and aggressive. They may have experienced abuse in their childhood and have poor control over their emotions.

The principal responsibility of the physician is to make the correct diagnosis, institute proper therapy, and take steps to prevent a repetition of the preceding events. He should report suspected willful injury to the police department. The physician's report should be objective and verified if possible by photographs and x-rays. The bias should be in favor of the child's safety and directed to prevent repeated trauma. Physicians should not return the child to a house where even a moderate risk exists.

All physicians are urged to become aware of the wide range of possible indicators of the battered child, to apply this knowledge in this syndrome to all cases they care for, and to report all cases where there is legitimate suspicion of a battered child.

The following abstract is a modification of Connell's:

BE CURIOUS ABOUT

C ontrast between history and findings
H ostile parents with rejected, neglected children
I njuries causing metaphyseal "corner" fractures*
L ong bone periosteal proliferation, unexplained*
D iffering stages of healing of "surprise" multiple bone lesions*

A ccident prone children, including burned, poisoned
B ouncing baby skull fractures and subdural hematomas
U nexplained convulsions, anemia, hematuria, ecchymosis, jaundice, ileus
S udden death of patient or previous siblings
E xtraordinary inquisitiveness and concern by parents

REFERENCES

1. Connell, J. R.: The Devil's Battered Children, *J Kansas Med Soc* 64:385-391 (Sept) 1963.
2. Physical Abuse of Children (Editorial), *New Eng J Med* 266:1063 (May 17) 1962.
3. Kempe, C. H., et al: The Battered Child Syndrome, *JAMA* 181:17, 1962.
4. Caffey, J.: Multiple Fractures in Long Bones of Infants Suffering from Subdural Hematoma, *Amer J Roentgenol* 56:163, 1946.

*Pathognomonic signs.



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Smith, Donald Ray, 3004 Blueridge Ave., Wheaton, Md.

Smith, Eugene Charles, 2nd and Baltimore Ave., French Quarter Motel, Ocean City, Md.

Smith, James Franklin, 818 Loyola Dr., Towson, Md. 21204

Sobota, Joseph Thomas, 5506 Johnson Ave., Bethesda, Md. 20034

Spiggle, Wayne Campbell, 411 N. Smallwood, Cumberland, Md.

Staheli, Harvey Kent, Kasiska Bldg., Pocatello, Idaho 83201

Stoehr, Naor U., Corner of Carroll Ave. & University Blvd., Takoma Park, Md.

Stolley, Paul David, 2306 Pickwick Rd., Baltimore, Md. 21207

Sulkowitch, Hirsh W., 192 State St., Portland, Me.

Sutton, Granger Gideon, Jr., 616 Carraway Rd., Baltimore, Md. 21229

Taylor, George Winston, Jr., 5981 Searl Ter. Bethesda, Md. 20016

Taylor, Robert Bruce, 700 Cathedral St., Baltimore, Md. 21201

Thomas, Edward Louis C., 7908 Rocton Ave., Chevy Chase, Md.

Torsney, Philip Joseph, Jr., 11009 Montrose Ave., Garrett Park, Md.

Van Arsdell, Ronald Dorr, 12610 South Western Ave., Los Angeles, Calif.

Vogel, Ellen Cornelius, General Delivery, Ocean City, Md.

Walker, William E., Jr., 2186 5th Ave., Apt. 2 L., New York, N. Y. 10037

Wardlaw, Lionel Alfred, 376 Midwood St., Brooklyn, N. Y.

Webster, John Blair, 13300 Georgia Ave., Silver Spring, Md.

Weinstein, George William, 9163 Springhill La., Greenbelt, Md.

Weir, Donald Douglas, University of North Carolina, School of Medicine, Chapel Hill, N. C.

Wierer, Charles Robert, 250 Pennsylvania Ave., Hancock, Md. 77631

Williams, Frank Mathews, 550 N. Broadway, Apt. 1010, Baltimore, Md. 21205

Wolfort, Francis Gabriel, Johns Hopkins, Dept. of Plastic Surgery, Baltimore, Md. 21205

Wood, William Barry, Jr., Johns Hopkins Hospital, Dept. Microbiology, 725 N. Wolfe St., Baltimore, Md. 21205

Young, William Werner, University Hospital, 22 S. Greene St., Baltimore, Md. 21201

Names and addresses of above physicians received too late to appear in the Directory of Registered Physicians.

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Maryland Passes PKU Legislation

BENJAMIN D. WHITE, MD, MPH

Chief, Division of Community Services for the Mentally Retarded, Maryland State Department of Health

CAROL LEE SCHULZ

Health Educational Assistant, Office of Public Health Education, Maryland State Department of Health, assigned to the Division of Community Services for the Mentally Retarded

In previous columns much has been written on phenylketonuria, the inherited metabolic disorder, which, unless treated in early infancy, may lead to severe degrees of mental retardation.

Active research has produced not only special, palatable diets substantially free from the offending substance, phenylalanine, but also simplified screening methods that make mass detection programs feasible.

Proof of the effectiveness of mass screening programs is the recorded results of a study conducted by Dr. Robert Guthrie, Department of Pediatrics, State University of New York at Buffalo. Using the inhibition assay testing method which he developed, more than 400,000 newborn infants in 29 states were tested between May, 1962, and December, 1963. Thirty-nine cases of phenylketonuria were found, representing a higher incidence than had been expected.

Based on the facts that early detection and treatment can prevent irreparable brain damage and that practical methods of screening all infants have been developed, the Maryland General Assembly, during its 1965 session, passed mandatory legislation for the screening for PKU.

The ruling, which became effective June 1, was sponsored by Delegate Louise Gore of Montgomery County and applies to all newborn infants except those born to parents who object to the test on the grounds that it will violate their religious beliefs.

As prescribed by the statute, the State Board of Health and Mental Hygiene has adopted a series of administrative regulations for carrying out provisions of the law. Approved June 25 with the effective date of August 1, the regulations include administration of the test, laboratory analysis, and recording procedures. It is highly recommended that the Guthrie inhibition assay method be used in the screening program.

NEWBORN TESTING

For each infant born in a Maryland hospital, the person in charge or his designated representative must administer a blood test for PKU not sooner than 24 hours after onset of milk feeding and prior to discharge.

When a birth takes place elsewhere, those persons required to prepare and file the certificate of birth are responsible for seeing that the blood test is conducted not sooner than 24 hours after the onset of milk feeding and not later than four weeks of age.

LABORATORY ANALYSIS

Laboratory analysis will be performed by the Maryland State Department of Health or by a laboratory certified by the Department to handle the blood examination. All tests should be forwarded to the laboratory within seven days after collection, with the laboratory reporting the results within another seven days.

Upon request to the Maryland State Department of Health, materials and instructions for the collection of the Guthrie blood test will be supplied

when the laboratory analysis is to be made by the Maryland State Department of Health. The Department will also provide laboratory diagnostic tests required for the definitive diagnosis and follow-up treatment of phenylketonuria.

REFERRAL INFORMATION

To assure that every newborn child is routinely tested, hospitals are responsible for developing adequate referral systems to reach those infants in the following categories:

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1) A newborn child who is discharged sooner than 24 hours after the onset of milk feeding.

2) A newborn child who is discharged before the blood test for phenylketonuria is collected.

3) A newborn child on whom the blood test for phenylketonuria is reported by the laboratory making the analysis as unsatisfactory.

4) A newborn child on whom the blood test for phenylketonuria shows the concentration of phenylalanine to be 4 mg% or greater.

Similarly, the Board's regulations stipulate that the persons responsible for preparing the birth certificate for a newborn child born outside a hospital make arrangements to retest in cases where the laboratory reports the blood test as unsatisfactory or to do additional tests on infants if the test shows the concentration of phenylalanine to be 4mg% or greater.

REGISTER TO BE MAINTAINED

Board regulations also charge the Maryland State Department of Health with the responsibility of maintaining records of every newborn child in whom the diagnosis of PKU has been confirmed. To keep the register current, the director of each approved laboratory conducting the blood analysis must notify the Department within two weeks of every new case in which a presumptive diagnosis of PKU has been made.

VOLUNTARY PROGRAMS IN EFFECT FOR A YEAR

Although the ruling went into effect on June 1, Maryland hospitals actually began pilot and voluntary programs utilizing the Guthrie screening method in January, 1964. By May of this year, 42 hospitals, accounting for 90.7% of births in the state, were participating. To date, the screening program has detected nine cases of PKU, and dietary treatment has been initiated.

REPEATED TESTING RECOMMENDED

Screening in the newborn period by no means replaces urine testing during infancy and early childhood. This practice should be a routine part of each physician's office procedure as well as an important part of all child health programs. For a baby's own protection, it is recommended that urine testing be repeated at least three times during the first six months of life.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

DEPARTMENT OF HEALTH

STATE OF MARYLAND

William J. Peeples, MD, MPH, *Commissioner*

Highlights

CHOLERA

A case of Asiatic Cholera was reported in a resident of Silver Spring. This man was accidentally infected while working with cholera in the Walter Reed Research Center in Washington. He had not been vaccinated. This is the second cholera case in six weeks from the same source.

RABIES

A case of rabies reported in a pet in the South River area of Anne Arundel County is the first case of dog rabies to be found in Maryland since January, 1962. The puppy was bought in Virginia on July 4, began acting queerly later, and on the 16th and 17th it bit five children in the family. It died on the 21st, and the head was brought to the central laboratory, where rabies was confirmed. Anti-rabies treatment has been started on the children. After the puppy became ill, the Maryland owner learned from the original owner in Virginia that the mother of the puppy had attacked a rabid fox early in June.

Six rabid bats were found in the Baltimore metropolitan area during July. This makes a total of 10 found in this area in the past eight months.

HEALTH COURSE EVALUATION

Forty students completed "Maryland's Health Programs in Action," a three-credit course sponsored by Towson State College. The Office of Public Health Education helped to set up the series, and many health and mental hygiene program directors participated in the lectures held at the State Office Building and in the field trips to health facilities. The enrollees, most of whom were elementary or secondary school teachers, felt the information would be useful in both classroom and home. Many thought it should be a required course for teachers. Some requested the course be held next year with supplemental subjects.

NEW CONTAINERS FOR PASTEURIZED CRABMEAT

The Division of Food Control reports approval of the use of a plastic container for pasteurized crabmeat. Bacteriologic tests as well as taste and odor tests performed by the University of Maryland Natural Resources Institute using Health Department standards have shown the containers provide an overall product protection equal to the metal cans now in use. Pasteurization of crabmeat provides a safer, longer lasting product. Since the plastic container may have added consumer appeal, it is hoped that it also will be a means of encouraging increased production and acceptance of the pasteurized meat.

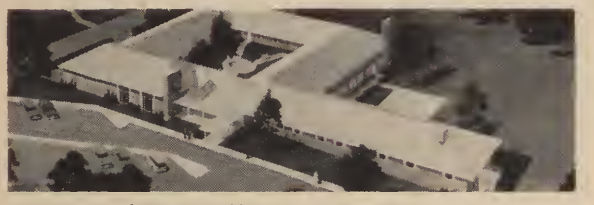
GRANT FOR MEDICAL REJECTEES

The U. S. Public Health Service has awarded $80,378 to the Maryland State Department of Health to establish and operate a program of counseling and referral services for armed forces medical rejectees. Recruitment is underway for a part-time physician, an administrator, two counselors, and supporting clerical staff to carry out these responsibilities.

GRANT FOR AIR QUALITY STUDY

A U. S. Public Health Service grant of $225,000 has been awarded to Maryland under the Clean Air Act, Section 3, for a Metropolitan Baltimore Air Quality Study. Total for the three-

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year study will be approximately $1 million. This represents a ratio of three to one in federal to state matching funds.

FIRE CODE FOR INSTITUTIONS

The Fire Prevention Code adopted by the State Fire Commission will have a profound impact on the institutions licensed by the State Department of Health, particularly nursing homes. The code requires that every institution having a capacity of four or more beds must be located in a fire-resistive structure or be protected by an approved sprinkler system. The Fire Commission set a practical schedule for compliance, reaching completion in 1969.

Through the combined efforts of the State Fire Marshal's office and local fire departments, with the State Department of Health, a reasonable state of fire safety has been maintained. However, the requirements of the new code will carry fire safety to a greater degree of fulfillment of the State Department of Health's responsibility to assure safety in institutions caring for patients.

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New Appointments

DR. DE HOFF—LOCAL HEALTH SERVICES

John B. De Hoff, MD, has joined the City Health Department as director of local health services, a position formerly held by the late Dr. W. Sinclair Harper. A native of Baltimore, Dr. De Hoff attended the Johns Hopkins University and received his MD degree from the School of Medicine in 1939. He served his internship at Mt. Sinai Hospital, New York City, and was a resident in psychiatry at the Payne Whitney Psychiatric Clinic of the New York Hospital for a year.

During World War II, Dr. De Hoff served four years in the Army Medical Corps as a laboratory officer and as a consultant in tropical diseases both at home and overseas. Dr. De Hoff returned to Baltimore in 1947, where he has practiced internal medicine until his present assignment in the City Health Department.

Dr. De Hoff is an associate in medicine at the University of Maryland School of Medicine. As colonel in the U.S. Army Reserve, he commands the 92nd Field Hospital, the Baltimore medical unit called to active duty during the Berlin Crisis.

DR. SWALLOW—MATERNITY CENTER

Kathleen A. Swallow, MD, MPH, has been appointed director of the Baltimore Maternity and Infant Care Project 501, a special five-year program inaugurated in 1964 to expand the Health Department's role in maternity and infant care. Dr. Swallow, a native of Canada, received her undergraduate and medical education at the University of Alberta and the Master of Public Health degree from the Johns Hopkins School of Hygiene and Public Health. Postgraduate training in pediatrics was received at the University of Alberta and at the Toronto General Hospital and the Hospital for Sick Children in Toronto.

During World War II, Dr. Swallow served as captain in the Royal Canadian Army Medical Corps. She later engaged in research and clinical work at Harvard University Medical School and the Massachusetts General Hospital. Before coming to Baltimore she was an associate professor in pediatrics at the University of Alberta. In February she was appointed assistant professor of pediatrics at the Johns Hopkins School of Medicine, and on July 1 she was made lecturer in maternity and child health at the Johns Hopkins School of Hygiene and Public Health. The Baltimore Maternity Center is located at 211 W Lombard Street, just behind the Baltimore Civic Center. At the Center, expectant mothers receive a complete physical examination, including a dental checkup with treatment if needed, and advice and guidance on prenatal care or family problems. Physicians may refer needy expectant mothers to the Center and should feel free to discuss their obstetric or pediatric problems with Dr. Swallow by calling 752-7282.

DR. JACOBSON—MENTAL HYGIENE

The City Health Department is pleased to announce that Wayne E. Jacobson, MD, has been appointed director of the Department's Bureau of Mental Hygiene. Besides having overall direction of the City Health Department's mental hygiene program, Dr. Jacobson will work with community agencies, serve as a liaison agent to coordinate the activities of the City Health Department and State Department of Mental Hygiene, and give advice and consultation on alcoholism, narcotics, and other related mental health

problems. Presently the City's chief mental hygiene services include two clinics for emotionally disturbed children, located in the Eastern and Western Health District buildings, a Psychiatric Day Center at 2111 N Charles Street, and an Alcoholism Clinic in the Eastern Health District Building, 620 N Caroline Street.

Dr. Jacobson graduated from the Johns Hopkins School of Medicine in 1949 and has been associated with the Hopkins Medical Institutions for about 10 years. From 1950 to 1955 he progressed from resident in psychiatry to chief resident at the Henry Phipps Psychiatric Clinic. Later he was named clinical director at Sheppard and Enoch Pratt Hospital in Towson. At the same time he was an instructor in psychiatry at Johns Hopkins as well as a psychiatrist in the Hopkins Psychiatric Liaison Service. In 1957 he became a research psychiatrist at Johns Hopkins and in 1960 left the city to become chief of inpatient service and assistant professor in the Department of Psychiatry at the University of California at Los Angeles.

In addition to serving in the City Health Department, Dr. Jacobson will be working in the Division of Community and Social Psychiatry of the Johns Hopkins Hospital and as associate professor in the Department of Mental Hygiene at the School of Hygiene. Dr. Jacobson is a member of the American Psychiatric Association and the author of several research studies in psychiatry.

MR. AYD—FOOD CONTROL

Mr. Jacque G. Ayd has been named director of the Bureau of Food Control. Formerly chief of the Division of Food Plant Inspection since 1952, Mr. Ayd has been with the Department since 1941, when he was appointed a senior sanitary inspector in the Bureau of Environmental Hygiene. In 1945 he transferred to the Bureau of Food Control.

A native Baltimorean and a member of a well-known East Baltimore medical family, Mr. Ayd is a graduate of Loyola High School and Loyola College and was awarded the Bachelor of Arts degree in 1937. He attended the University of Baltimore Law School and received the LLB in 1947 with honors including the Heuisler Honor Society Award for excellence in scholastic studies. He has been a member of the Maryland Bar since 1948.

Mr. Ayd is a registered sanitarian with the National Association of Sanitarians and is past president of the Baltimore Conference and the Central Atlantic States Associations of Food and Drug Officials. He has served for a number of years on the executive committee of the Interstate Sanitation Seminar.

Robert E. Farber, MD
Commissioner of Health

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STATE OF MARYLAND

Department of Mental Hygiene

Fact Sheet for 1965 Fiscal Year

Fiscal Year	Average Size of Patient Population	Total Number Treated During Year	Admissions	Discharges
1955	9,424	14,865	3,565	4,031
1960	8,576	16,268	4,640	4,751
1961	8,428	16,783	5,266	5,425
1962	8,291	17,580	6,221	6,111
1963	8,218	18,726	7,257	7,173
1964	8,035	19,424	7,871	8,104
1965	8,076	19,688	8,551	8,060
Net Change	−1,348	+4,823	+4,986	+4,029
Percentage Change	−14.3	+32.4	+139.9	+100.0

IN 1965, FOR THE SIXTH YEAR in a row, Maryland's hospitals for the mentally ill treated a record number of patients, reflecting the continuing rise in admissions. Despite a gradual decrease in the length of hospitalization of newly admitted patients, the average size of the patient population increased for the first time in more than 10 years. This is believed to be a major reversal of what had been a long range downward trend. If this should persist as expected, it would have major policy implications. These data are summarized in the table.

The continuing rise in the number of mentally ill patients treated annually reflects mainly the rapid expansion in admissions. The 8,551 patients admitted during 1965 represented an increase of 8.6%, or 680, over the previous year's comparable figure and a rise of 139.9%, or 4,986, during the past 10 years. Similar trends have been observed in most states. Because of this, the question is frequently posed whether this indicates a rising incidence of mental illness. This cannot be readily answered since the numeric relationship between the number of hospitalized patients and the total number of mentally disturbed cannot be determined. It is generally believed that the incidence rate of most types of mental illnesses has not changed appreciably and that these expanding figures therefore reflect mainly the growing acceptance and usage of mental hospitals as short term treatment facilities for acute disturbances.

Substantial overcrowding continued at Rosewood, Maryland's major hospital for the mentally retarded. The Department therefore persisted in its policy of relating the number of mentally retarded admissions to available space and staff. Despite this restrictive policy, the average number of retarded patients at Rosewood and Henryton increased from 85 to 2,701. Ten years ago, before the opening of Henryton, Rosewood had a patient population of 1,657. In an effort to remedy this chronic problem, the Department is engaged in a three-pronged program involving the construction of additional buildings at Rosewood, the establishment of new facilities in the Baltimore and Washington metropolitan areas, and the development, with the Health Department, of coordinated community based services as alternatives to hospitalization.

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What Happened to Maryland Physicians' Income in 1964?

WILBURN L. McCLURE, JR.

THE BIG RISE IN MEDICAL EARNINGS seems to be over. After doubling their net incomes since 1950 and surging far ahead of any other occupational group, self-employed physicians now see their practice expenses rising faster than their gross receipts.

"Do you think this leveling off will continue?"

This surmise and this question were posed recently by the editor of a leading magazine. Before answering, it was decided to do some checking on how physicians in the Maryland-District of Columbia vicinity have fared with their net professional incomes.

The actual income and expense figures, taken from more than 200 separate physicians' federal income tax returns kept for the past 10 years, seemed the best way to test the accuracy *for this region* of the assumption that doctors' incomes are lessening. With one exception, out of those surveyed, physicians are more prosperous in this region than ever before.

By way of explanation, the dollar figure in the first column is the average net professional income for the five-year period from 1958 through 1962 of doctors the author could easily survey, statistically, from actual records. The second column shows the average net income of the same doctors for the year 1963. Large as is the difference between these two columns, the variation would have been even greater had an average been used over a ten-year period.

If the national trend is really leveling off, these figures for the Maryland-DC vicinity are notable for their nearly complete exceptions. Remember, this analysis was derived from authentic figures representing attested income-return records.

Average Net Income Figures		
	Actual 5-Year Average 1958 through 1962	Actual 1963 Only
Physicians	$25,987.25	$33,512.75
Surgeons	$34,644.00	$43,193.60

Should you disagree with the above conclusions, a glance at next month's column, "Your Most Valuable Asset," might be in order.

Anthony R. Fiorilli

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COUNTWAY LIBRARY DEDICATED*

Dedication of the Francis A. Countway Library of Medicine took place at the Harvard Medical School in Boston on May 26 and 27, 1965. This constituted the formal presentation to the area's medical community of the largest university-centered medical library in the nation, comprising the combined resources of the Boston Medical Library and the Harvard Medical Library.

The ceremonies opened with the first of three seminars, which centered on "The Significance of Medical History," and was presided over by Dr. George P. Berry, Dean of the Harvard Faculty of Medicine and Professor of Bacteriology. Participants were Dr. Owsei Temkin, William H. Welch Professor of the History of Medicine and Director of Johns Hopkins University's Institute of the History of Medicine, who spoke on "The Meaning of Medicine in Historical Perspective"; Dr. Dickinson V. Richards, Lambert Professor *Emeritus* of Medicine, Columbia University College of Physicians and Surgeons, speaking on "The Uses of History in Medicine"; and Dr. George W. Corner, Executive Officer, American Philosophical Society, who spoke on "The Medical Library: Where Past and Present Meet."

Guests at the dinner that evening were addressed by Dr. Lloyd G. Stevenson, Chairman of the Department of the History of Science and Medicine at Yale University, whose topic was "On Being a Medical Historian."

The subject of the second seminar on the following morning was "The Scientific Information Problem and the Library," with Dr. Merle Fainsod, Carl H. Pforzheimer University Professor and Director of the Harvard University Library, presiding. Speakers included Dr. Herbert Menzel, Bureau of Applied Social Research, Columbia University, who spoke on "The Information Gathering Practices of the Scientific Investigator and the Medical Practitioner"; Mr. Ralph T. Esterquest, Librarian of the new Countway Library, speaking on "The Francis A. Countway Library of Medicine: Its Response to the Needs of Today and Tomorrow"; and Dr. Martin M. Cummings, Director, National Library of Medicine, whose address was entitled, "The Edge of Husbandry: The Role of the National Library of Medicine."

"The Challenge of the New Technology" was the subject of the third seminar, presided over by Mr. Douglas W. Bryant, the Harvard University Librarian. Dr. Mortimer Taube, President, Documentation, Inc., spoke on "Information Technology: Its Problems and Its Promises," and Dr. Raynard C. Swank, Dean of the School of Librarianship, University of California at Berkeley, closed the session with "The Library Accepts the Challenge."

The dedicatory ceremonies occurred in the late afternoon of the second day. After brief addresses by Dr. Berry, Dr. Howard B. Sprague, President, Boston Medical Library, and Archibald MacLeish, Boylston Professor of Rhetoric and Oratory *Emeritus*, Harvard University, and former Librarian of Congress, the formal words

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of dedication were pronounced by Dr. Nathan M. Pusey, President of Harvard University.

At the prededication dinner meeting, Dr. Stevenson presented to Dean Berry as a gift from the Yale Medical Library to the Countway Library a rare edition of a medical test written by Gariopontus, one of the oldest of the known masters and writers of the world's first medical school at Salerno, Italy.

The edition, originally written in the late tenth or early eleventh century, was printed at Lyons in 1516. Entitled *Ad totius corporis aegritudines remediorum,* it is a compendium of practical medicine compiled from the works of Hippocrates, Galen, Alexander, and others. The small quarto volume is bound in full contemporary vellum and also contains the author's treatise, *De febris.*

The author, Gariopontus, probably came from Lombardy, possibly from Naples, and lived at Salerno toward the end of the tenth and the first half of the eleventh centuries. The approximate year of his death has been placed at 1050 A.D. Of his writings, only the work presented to the Francis A. Countway Library of Medicine and a treatise on fevers are known today.

MEDICAL HISTORIANS, NOTICE!

The Hafner Publishing Company will offer an annual award of $200 for a meritorious article on the history of medicine dealing with a single individual who has made a contribution of historical interest. Sponsored by the American Association for the History of Medicine and the Medical Library Association, it will be made for an article originally published in the English language during the previous calendar year. The committee solicits nominations, to be submitted before April 15, 1966, for articles published in 1965. The prize will not be given if, in the committee's opinion, no article appearing in that year is worthy of the honor.

The award will be made alternately at the annual meetings of the sponsoring organizations. In 1966, the presentation will be made at the meeting of the American Association for the History of Medicine, convening in Rochester, Minn. Nominations should be sent to the committee chairman, Dr. Owsei Temkin, director, Institute of the History of Medicine, 1900 East Monument Street, Baltimore, Md. 21205.

—Bull MLA July 1965

NEWS ON MEDICAL LIBRARY ASSISTANCE ACTS

Hearings on the Medical Library Assistance Act of 1965 (S 597 and HR 3142) were held before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare on June 14 and 15, 1965.

As of July 29, 1965, the Senate bill, S 597, was still in committee, the report on the Senate hearings was published, and the House hearings had not been held. The act had received the approval of President Johnson earlier in the summer.



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The House of Delegates, AAMA's policy-making body, will convene Wednesday, October 13, and continue through the next day. Friday and Saturday are devoted to the educational programs, with association workshops highlighting the Saturday proceedings. Workshop topics will include parliamentary procedure, certification, membership, leadership, public relations, and treasurers.

Before the formal opening of the meeting, special tours and events have been arranged for the medical assistants. October 11 is Medical Assistants Day at the World's Fair, with a VIP tour of the GE Futurama, a visit to the Atomedic Hospital, and brunch at the Top of the Fair Special admission to other exhibits has been arranged.

During a visit to the UN on October 12, AAMA delegates will hear a special message from a member of the World Health Organization. A tour of Rockefeller Center, featuring a fiesta brunch at La Fonda del Sol, highlights Wednesday morning. On Friday, AMA president, James Z. Appel, MD, will speak at a luncheon honoring AAMA past presidents. The awards luncheon on Saturday will honor those medical assistants who have become certified, as well as state chapters which have been judged outstanding in the areas of membership and publications. Scholarship fund certificates will also be presented.

Climaxing the week's events will be the Saturday banquet honoring state chapter presidents. At that time, AAMA president, Mrs. Rose Merritt, Savannah, Ga, will present the outstanding merit and honorary membership awards, and Miss Marge Slaymaker, Newton, Kan, will be installed as 1965-66 president

Delegates and alternate representing the Maryland Association of Medical Assistants are as follows:

From Baltimore
Delegate, Bernadette Gurny
Alternate, Rita Cobry
From Allegany-Garrett Counties
Delegate, Mabel Young
Alternate, Mary Crock
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Woman's Auxiliary

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SEPTEMBER, 1965

MRS. IRVING J. TAYLOR, *Auxiliary Editor*



Inaugural Address

MRS. MARTIN E. STROBEL

When I was a student at Western Maryland College, I attended a conference at Dickinson College in Carlisle, Pa. I was quite impressed by a statement made by one of the professors during the discussion. He said that he believed that life is like a series of forks in the road and that we have certain choices to make as to which course we will follow. However, after making the choice, certain inevitable outcomes will result. They might not be what we expect or desire; but, nevertheless, they will occur.

Subconsciously, I think I accepted this theory, and it has become a philosophy of mine. We all try to reach ultimate destinations. Sometimes it is not easy. There may be flat tires, detours, inclement weather, or accidents. Once we select a particular road, however, we must have determination and perseverance to pursue its path despite obstacles if we expect to attain our goal. Patience and understanding are also involved in this pursuit.

The success of the activities of this auxiliary during the coming year will depend upon the participation of each member and her willingness to meet each new challenge as it arises.

Remember that it is a privilige to be a member of this group and that most of us are members of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland only because we married doctors. It is our purpose to help in whatever way we can to promote the goals of the Faculty.

Several years ago, at an AMA convention, Mrs. Harlan English gave an excerpt from the book *Bleak House* by Charles Dickens. I shall never forget it. Although I can't do justice to it, and I hope Mrs. English will forgive my attempt, I should like to share it with you.

. . . I never walk out with my husband, but I hear the people bless him. I never go into a house of any degree, but I hear his praises, or see them in grateful eyes. I never lie down at night, but I know that in the course of that day he has alleviated pain, and soothed some fellow creature in the time of need. I know that from the beds of those who were past recovery, thanks has often often gone up, in the last hour, for his patient ministration. Is not this to be rich?

AUXILIARY GETS ITS OWN OFFICE

We now have a small office on the fourth floor of the Med-Chi Building. Mrs. Kathryn Brooks has been assigned to help the auxiliary members. Committee chairmen and others who wish to schedule meetings at the Med-Chi are asked to notify Mrs. Brooks in advance.

MARYLAND WINS AMAERF AWARD

At the convention of the Woman's Auxiliary to the American Medical Association, in New York, it was announced that Maryland won one of six national awards for AMAERF contributions. We took first place in our membership category, meaning that among state auxiliaries of comparable membership we raised the most money. In the eastern regional contest for AMAERF, both Allegany and Montgomery Counties won first place in their respective membership categories. Mrs. Wallace H. Sadowsky is AMAERF chairman for our state.

Another AMAERF Fund Day will be held November 10 at the Med-Chi building, from 10 AM to 3 PM. This annual event has proved so successful that many presidents from other states have asked to visit our affair so that they might try the same thing in their own states.

MRS. STONE JOINS NATIONAL BOARD

We are honored that Mrs. William S. Stone has been made a member of the National Board of Directors of the Woman's Auxiliary to the AMA. Another honor went to Mrs. John E. Baybutt, our past president, who was named eastern regional chairman for the AMAERF Committee.

Mrs. L. Louis Mould

President, Woman's Auxiliary to the Allegany County Medical Society

Mrs. Margaret G. Mould hails from Smith's Falls, Ontario, Canada. She attended local schools there and in 1948 graduated from Brockville General Hospital School of Nursing, Brockville, Ontario.

She met Dr. L. Louis Mould before he entered medical school in 1946.

She worked at Kingston General Hospital, Kingston, Ontario, and St. Mary's Hospital, Montreal.

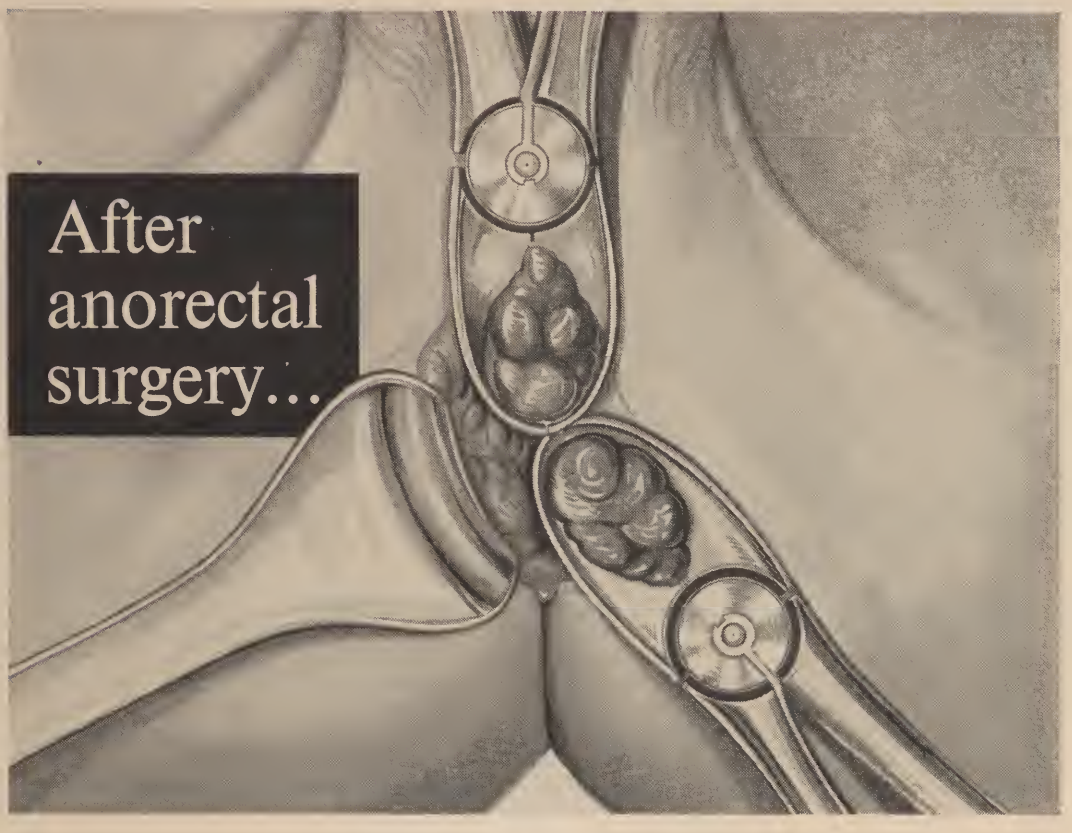
The Moulds moved to Baltimore in 1954. In 1957 they moved to La Vale, where they are still living. Mrs. Mould retired from active nursing in 1957. She has three children: Pamela, 14, John, 9, and Alison, 7.

Mrs. Mould became treasurer of the Allegany County Auxiliary in 1963 and held the job until she became president this year.

INTERNATIONAL HEALTH COMMITTEE

A new committee on international health has been formed with Mrs. Leland Ransom as chairman. She has asked that any auxiliary member who would like to entertain foreign doctors in her home or by any other means should notify Mrs. Brooks, 539-0872. This is one of the ways in which the International Health Committee hopes to foster better relations with our foreign doctors.

Those members who would like to contribute to our international health activities by donating any of their husband's old medical journals, books, and drug samples may do so by contacting the county International Health chairman, if there is one, or Mrs. Brooks in the state auxiliary office.



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When a group of market men, butchers, and groceryman from the Lafayette Market area met on Monday, May 5, 1884, in Louis Meyer's Tailor Shop, 476 Pennsylvania Avenue, to form the Pennsylvania Avenue Permanent Building Association, little did any of them realize that the association would grow and prosper into one of the nation's largest, with assets today approaching $300,000,000.

Baltimore Federal Savings and Loan Association traces its history back to that date, when the minute book shows that Gustav Bueschal was elected president. Another entry shows "Amounts of shares taken in — 93; Receipts — $46.50; Amount in treasurer's hands — $46.50."

Other records show that it took one month for the organization to accumulate enough cash to make its first loan of $600 to John Gith. This was on June 10, 1884. Since then the association's lending division has financed more than 50,000 homes in Maryland.

Begun as a neighborhood venture to promote thrift and encourage home ownership, members started by putting 25 and 50 cents a week into savings accounts. It is interesting to note that at the end of June, 1965, savings accounts at Baltimore Federal totaled more than $239,000,000.

The association later moved to Sewell Street and Argyle Avenue, then to 1504 Pennsylvania Avenue, where it operated on a one-night-a-week schedule. The association was operating on this basis when Henry Pitman Irr joined the organization as a teller and general manager.

Soon after, the association began to grow, and it was necessary to move headquarters to 2404 Pennsylvania Avenue, where additional space permitted a greater number of working hours and a consequent increase in business. In 1935, the association applied for and was granted a federal charter and took the name of Pennsylvania Avenue Federal Savings and Loan Association. In 1938, with assets of $3,000,000, it moved to 19 East Fayette Street and changed its name to Baltimore Federal.

With federal provisions for insurance of accounts and with an expanding loan business, the firm doubled in size during its first year downtown. Mr. Irr was elected president in 1944 and announced that the association had purchased the Fayette and St. Paul Street corner—its present location. In 1950 Baltimore Federal completed construction of its present colonial building featuring the architecture of St. Mary's City and Williamsburg. The building is now one of the landmarks of downtown Baltimore.

Assets reached $100,000,000 in 1954, and the association completed the installation of a 69-bell carillon, the music of which brightened Baltimore's financial district. Three years later assets passed $200,000,000, and in 1958 the association added a new wing to its downtown building.

In 1961 Baltimore Federal established its first branch locations in Eastpoint and Westminster and the following year in Reisterstown Road Plaza and Towson. Last year the association merged with Carney Federal and established its Carney office.

Under the direction of Henry P. Irr, president, Baltimore Federal instituted many local savings and loan firsts. Among them were the GI home loan program after World War II, when Baltimore Federal took the initiative and led all others in making home loans to returning veterans.

In 1955 it became one of the first savings and loan associations in the nation to install electronic accounting equipment. Subsequent growth required installation of a computer, which went into operation in April of this year.

In March, 1964, the association introduced its Monthly Income Plan (MONI), which was designed mainly to supplement retirement or social security income. Actually, the Monthly Income Plan provides a choice of two distinct plans: the Term Moni Plan, which offers a monthly check for a specific number of years, and the Permanent Moni Plan, which gives a monthly income check for as long as desired (even for life). Response to the plan was heavy, particularly among members of the medical profession.

This past June the association scored still another first when it entered the college education loan field. This marked the first time a local savings and loan had offered loans under new authority granted by the Federal Home Loan Bank Board, which had previously restricted savings and loans to lending only for the building, purchase, or improvement of the home. The day after the new program was announced, the association had made its first college loan.

Guiding the association today, in addition to Mr. Irr, are Eugene K. Reilly, executive vice president; Charles E. Williams, senior vice president; Francis Drake, vice president; T. Frank Sheehan, secretary; Louis A. Hogan, treasurer; and William W. Simpson, comptroller, aided by a capable staff which specializes in friendly, personalized service.

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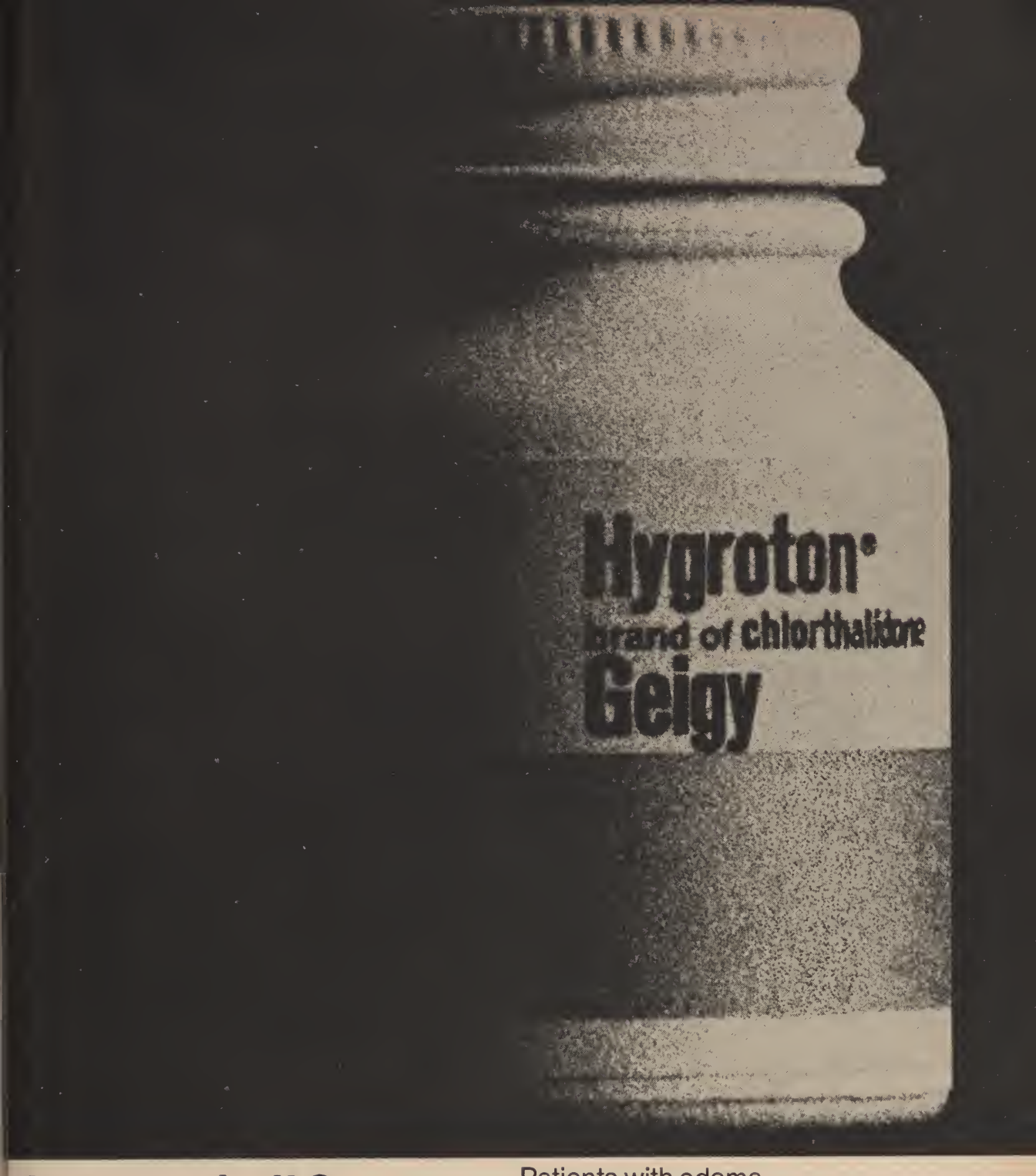
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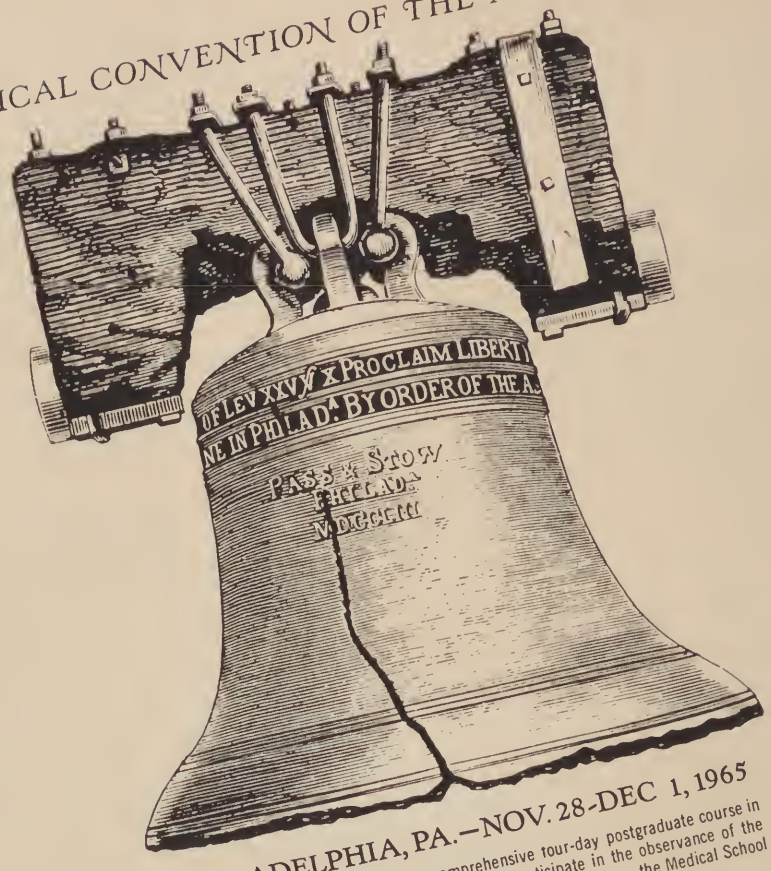
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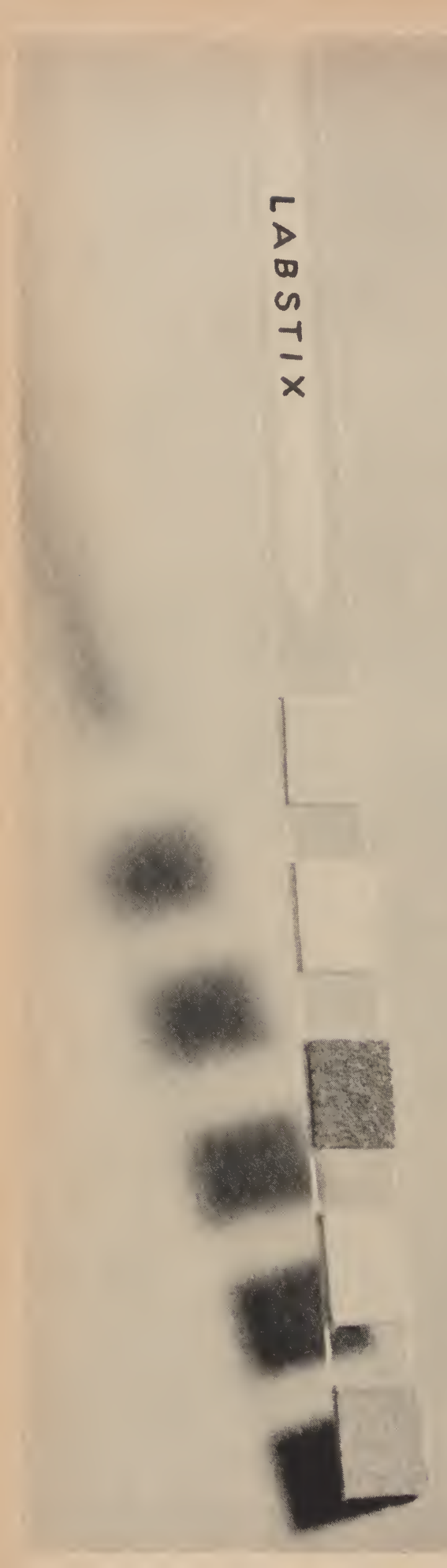
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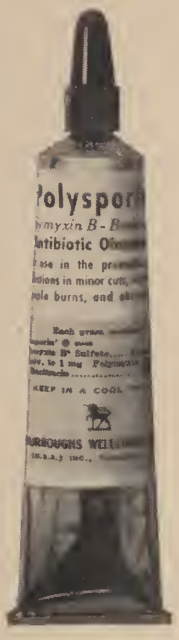
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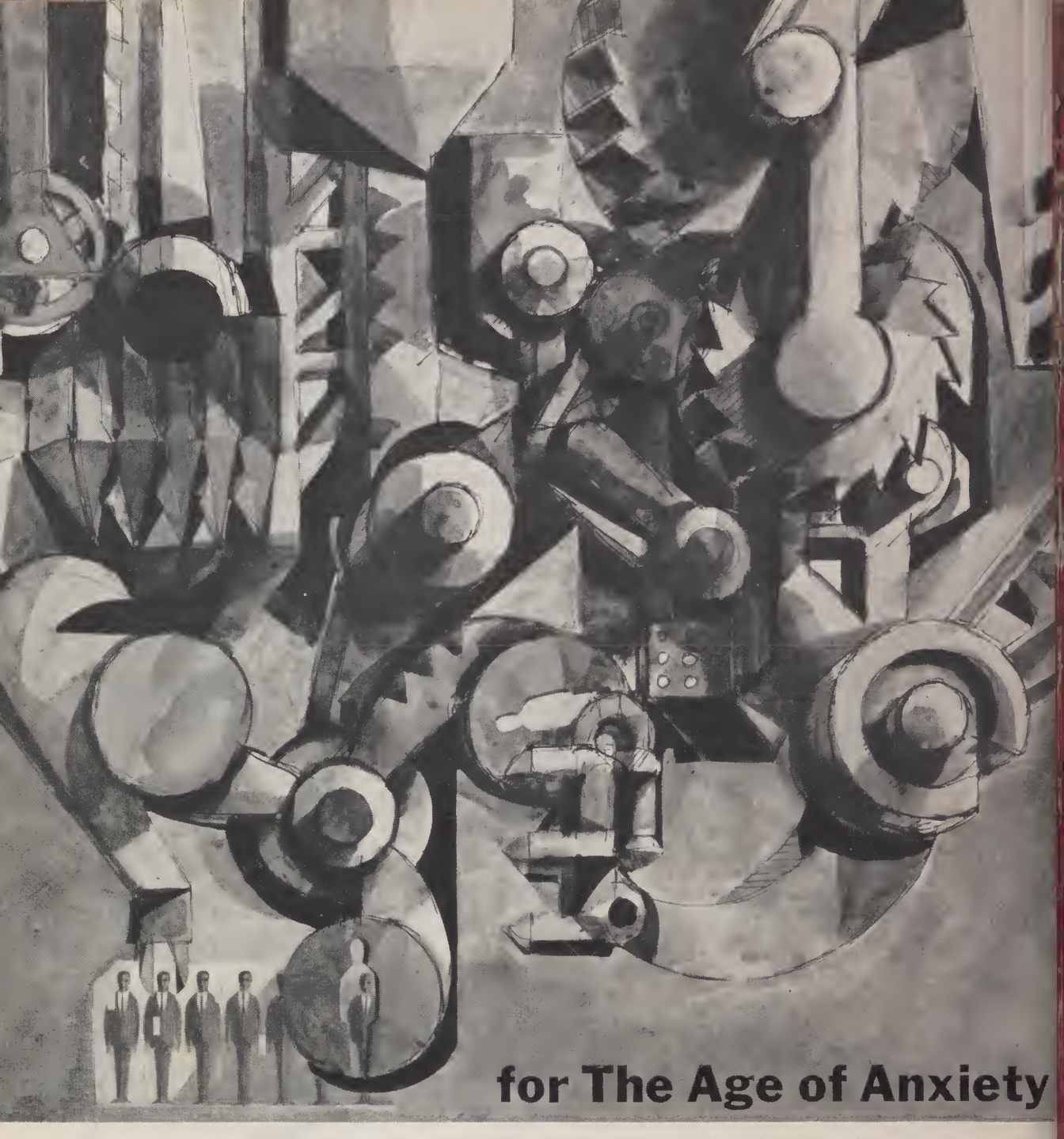
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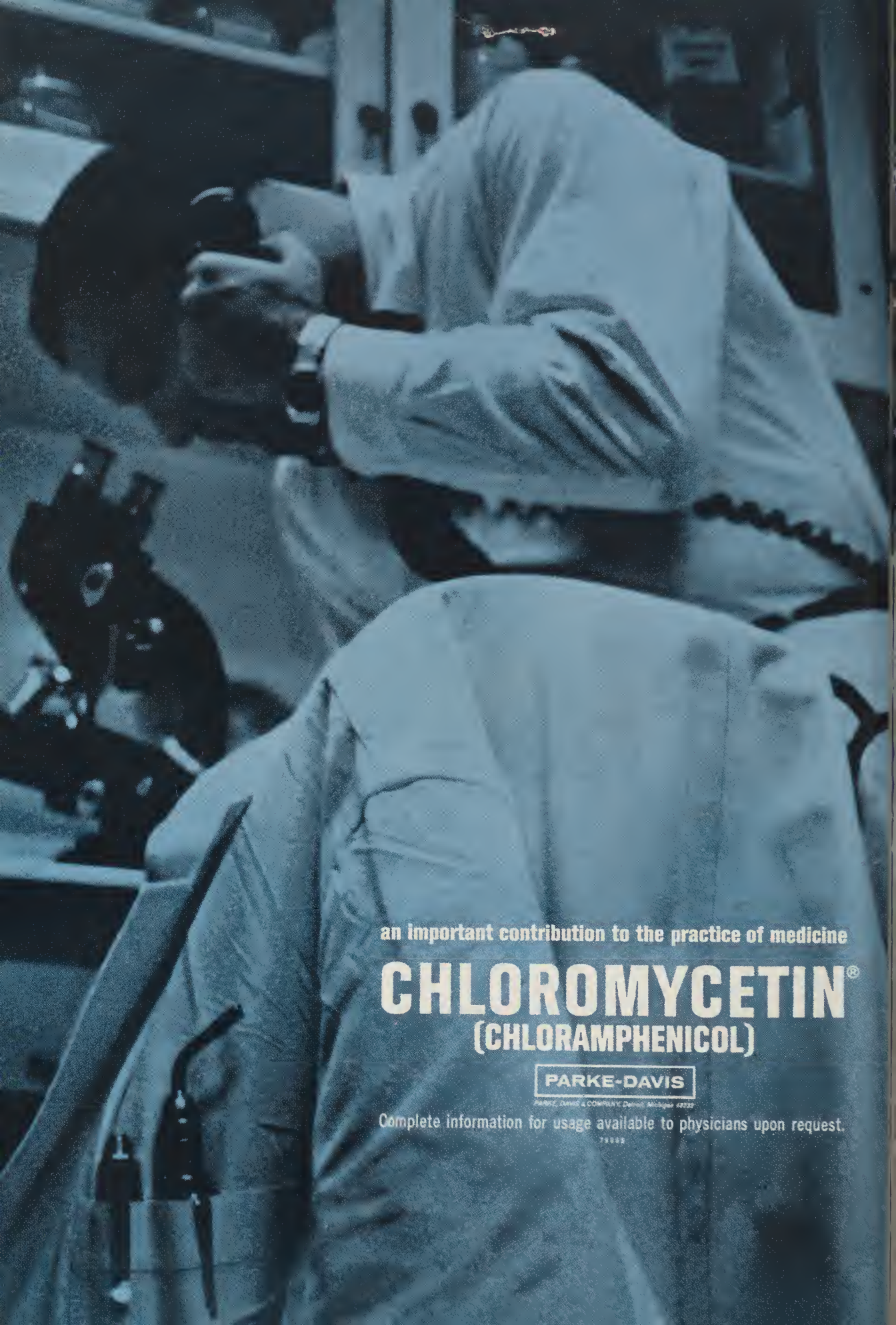
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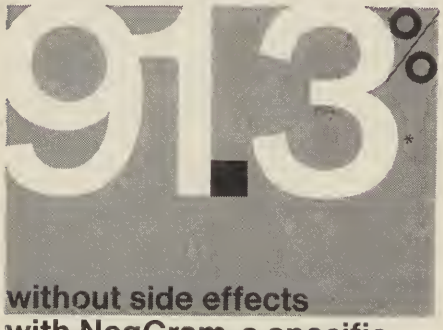
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†STEDYTABS DELFETA-SED are so prepared that the active ingredients are released continuously to provide for prolonged therapeutic effects for a period of up to 8 to 10 hours.

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MARK THESE IMPORTANT DATES ON YOUR CALENDAR

November 28-December 1—AMA Clinical Convention, Philadelphia.

April 27-May 4, 1966—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland. April 27-28, Baltimore—April 29-May 4, Aboard ship and in Bermuda

BALTIMORE CITY MEDICAL SOCIETY

November 5—8:30 PM—1211 Cathedral St., Baltimore

"Medical Education: Medical Progress—Its Direction." Samuel Morrison, MD, Moderator. Participants: William S. Stone, MD, Director, Medical Education and Research, and Dean, University of Maryland School of Medicine; Thomas B. Turner, MD, Professor of Microbiology and Dean of The Johns Hopkins University School of Medicine; Warde B. Allen, MD, Associate Professor of Medicine, The Johns Hopkins University, School of Medicine; Ivan L. Bennett, Jr., MD, Professor of Pathology, The Johns Hopkins University School of Medicine; Odom N. Coker, MD, Director of Medical Education, Provident Hospital; E. S. Ellison, MD, Former Chief of Staff, Franklin Square Hospital; William F. Renner, MD, Chief of Staff, Union Memorial Hospital; Instructor in Medicine, The Johns Hopkins University School of Medicine; George H. Yeager, MD, Professor of Clinical Surgery, University of Maryland School of Medicine and Director, University Hospital. Acceptable for 2 hours Category 1 Credit by the American Academy of General Practice.

AMERICAN COLLEGE OF CHEST PHYSICIANS

October 31—Holiday Inn, Charleston, Va.

Twenty-first annual meeting of the Potomac Chapter ACCP. All day program. Open to all physicians. No registration fee.

SEMINAR ON IMMUNIZATION

November 9—8 PM—1211 Cathedral St., Baltimore

Joint meeting of Maryland Pediatric Society and Maryland Chapter, American Academy of Pediatrics. Provided through the CDC Seminar Service Program. "Disease Status Reports," David MacKenzie, MD, Editor, Morbidity and Mortality Reports, Epidemiology Branch, Communicable Disease Center, Atlanta. "A Combined Discussion of Schedules for Immunization and Precautions, Contraindications, and Complications Relative to Immunizing Procedures," Lewis L. Coriell, MD, Research Director, South Jersey Medical Research Foundation, Camden. "Rubella, Recent Advances," Stanley A. Plotkin, MD, Wistar Institute, Philadelphia.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

November 2—7:30 PM—1211 Cathedral St., Baltimore

"The Anesthesiologist as a Medical Consultant," Barnett A. Green, MD, Brooklyn, N. Y.

MARYLAND ENT SOCIETY

November 9—Sheraton Belvedere Hotel
Cocktails 6:30, Dinner 7:30, Speaker 8:30

"Otological Problems," George E. Shambaugh, Jr., MD, Professor of Otolaryngology, Northwestern University Medical School.

DIABETES DETECTION WEEK

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BALTIMORE CITY DENTAL SOCIETY

November 17—3 PM—Sheraton Belvedere Hotel

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CARIBBEAN SEMINAR CRUISE

October 29-November 12

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MARYLAND PSYCHIATRIC SOCIETY

November 11—8:30 PM—University Hospital

"Brain Damage and Behavior," Edwin A. Weinstein, MD, Washington School of Psychiatry.

AMERICAN COLLEGE OF GASTROENTEROLOGY

October 25-27—Bal Harbour, Fla.

Thirtieth annual convention at Americana Hotel. Immediately after the convention, the Annual Course in Postgraduate Gastroenterology will be held. American College of Gastroenterology, 33 W 60th St., New York, NY 10023.

AMERICAN ACADEMY OF PEDIATRICS

October 23-27—Chicago

Thirty-fourth annual meeting at the Palmer House. Program includes seminars, round table discussions, film program, and scientific and technical exhibits. American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill.

OTOLARYNGOLOGIC ASSEMBLY

October 30-November 5—Chicago

Department of Otolaryngology of the University of Illinois College of Medicine offers a condensed postgraduate basic and clinical program for practicing otolaryngologists. Medical Center, P.O. Box 6998, Chicago, Ill 60680.

ANIMAL CARE PANEL

November 15-19—Philadelphia

Sixteenth annual meeting, Sheraton Hotel. Write to executive secretary, Mr. Joseph J. Garvey, 4 E Clinton St., Joliet, Ill 60434.

UNIVERSITY OF MARYLAND POSTGRADUATE COURSES

1. CLINICAL CARDIOLOGY—November 11

Under direction of Leonard Scherlis, MD: Advances in diagnostic methods and management of the more common clinical problems in cardiology.

2. EYE, EAR, NOSE & THROAT—December 2

Under direction of Cyrus L. Blanchard, MD, and Richard D. Richards, MD: The practical problems of ophthalmology and otolaryngology with which the practicing physician must be conversant.

3. NEUROPATHOLOGY FOR PATHOLOGISTS—December 6-11

Under direction of John A. Wagner, MD: Given at the practical level and including basic neuropathology, trauma, tumors, infections and degenerative diseases; surgical neuropathology; the neurological clinicopathological conference; and practical drill in cutting, blocking, staining, and microscopic study of provided specimens.

4. SURGICAL PHYSIOLOGY—December 16

Under direction of Arlie R. Mansberger, MD: Preoperative and postoperative physiology, functional derangements, and management of the clinical problems commonly presented by the surgical patient.



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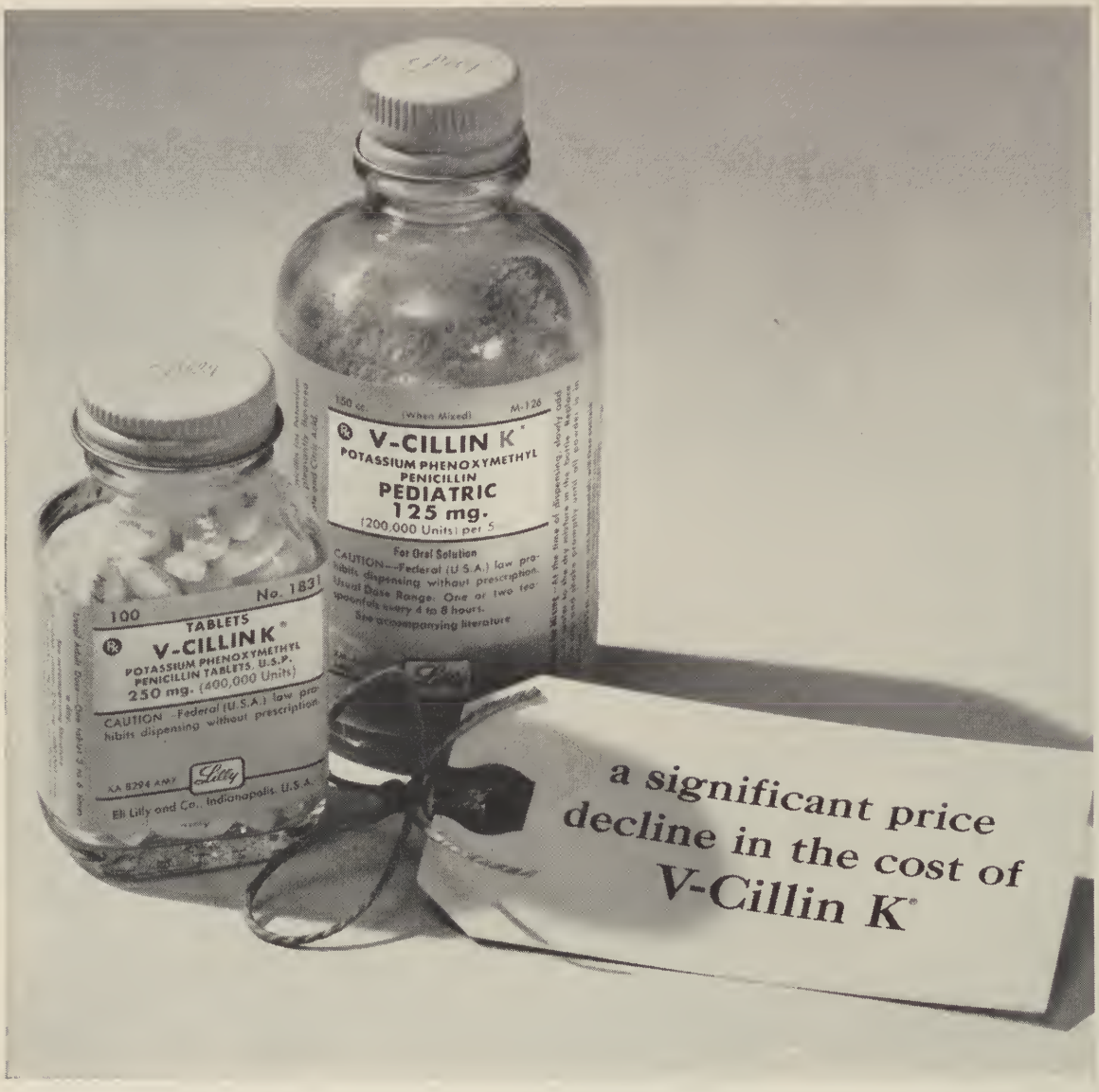
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Maryland State Medical Journal
Vol. 14, No. 10
October, 1965

Editorial

THE EDUCATED HAND

SAMUEL MORRISON, MD
President, Baltimore City Medical Society

THE HIGHLY SKILLED human hand has no substitute. It gives its ultimate contribution in the examination of the abdomen. It not only senses but almost hears and sees and, sometimes by indirection, makes a diagnosis often missed by modern tools. It translates to the brain the softness or firmness or degree of muscle rigidity in the abdomen; it also outlines with accuracy the size, descent, firmness, or hardness of liver, spleen, kidneys, and other objects, solid or not, which may be present. It can tell better than the x-ray, the extent, degree, and position of spasm in the intestinal tract. It is a tool which is always with the examining physician, and he need not remember, as he must with the stethoscope, flashlight, tongue depressor, and other weightier and expensive modalities, whether he had brought it with him.

This same educated hand can be used in other areas of the body, but it will not be my purpose to go into detail except to say that, as noted by Dr. Gelfand,[1] "It pays to palpate." Dr. Gelfand also writes about palpation in the head, neck, chest, the extremities, and the vascular system, and notes especially the old adage that "No examination is complete without a rectal examination." As an example of the educated hand's ability, trained

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clinicians have often preferred it to translate what is going on in an organ, such as the liver, over and above the data which fill many of our hospital records, as valuable as are the latter.

In this age of computers in medicine, writes Dr. Feinstein,[2] it must be remembered that they create a strange and marvelous paradox; they are inanimate and dehumanized, yet they can intellectually contribute more to humanism than almost any other advance of scientific technology. Although computers and logical clinical thought are compatible with care and compassion, the patient, especially the seriously ill patient, needs both the art and science of medicine. Whereas the computer has no subconscious, no intuition, no active sensory organs, and none of the imagination of a human intellect, the human hand, the educated one, has all these things and behind it, the human being whose brain is ready to make the interpretation.

The other side of the coin has to do with what your hands tell about you.[3] To Michelangelo, "Hands were objects of grace and beauty holding the key to character and personality"; to Sir Arthur Conan Doyle, "Hands not only reflected character, but often held clues to a man's occupation, habits, or recent whereabouts"; and to Sir William Osler, "Hands were all of this, plus a key to diagnosis as well."

The theme of my editorial lays emphasis on the educated hand and what it will reveal if properly used.

REFERENCES

1. Gelfand, M. L.: *Consultant* 4:26 (March) 1964.
2. Feinstein, A. R.: Computers in Medicine, *JAMA* 188:1020 (June 15) 1964.
3. Andreas, B. F.: *Blue Print for Health* (Fall) 1964.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.



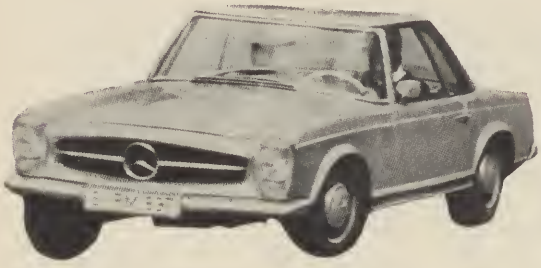
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EXECUTIVE SECRETARY'S NEWSLETTER

October, 1965

VIOLATIONS OF MEDICAL PRACTICE ACT

The Board of Medical Examiners has brought to the attention of the Faculty that physicians are violating the Medical Practice Act when they insert advertisements in newspapers or other media.

The Board warns that all physicians who have received licenses in the last 8 - 10 years have also received a copy of the Medical Practice Act and have been instructed to familiarize themselves with it. Violations of the Act will require that physicians appear before the Board for appropriate disciplinary procedures.

A full text of the Board of Medical Examiners correspondence in this area can be found in the November issue of the JOURNAL.

PHYSICIAN'S ETHICS

The Faculty has adopted a report outlining the standards to which physicians must adhere if they are to remain ethical.

One of these criteria is "mail-order" laboratory service. Currently physicians in this area are being solicited by mail and in person with literature by several out-of-state laboratories. Physicians should be cognizant of the requirements of the Faculty; and also recognize the difficult position in which they would be placed should test results prove defective. Also, physicians are reminded that out-of-state laboratories cannot be controlled, regulated or supervised by Maryland authorities.

Some laboratories, not physician owned or operated, are prescribing anticoagulant dosage based on their prothrombin determination. This is a clear violation of the Medical Practice Act. Instances where this occurs should be reported to the Faculty office.

MEDIATION COMMITTEE ACTIVITY

Recently, in the course of a discussion in the Mediation Committee, it was ascertained that a physician was accepting cases on a "contingency"

basis, when these cases were pending before the court.

The Judiciary has also indicated its concern over cases coming before it and the credibility of physician witnesses.

These matters and other similar ones are covered in the Medicolegal Code of Cooperation, approved by the Bar Associations and the Faculty. Copies are available through the Faculty office.

Disciplinary action against offenders will be taken by the Mediation Committee in cooperation with the Board of Medical Examiners.

NEWS NOTES

Augusto Esquibel, M.D., College Park, is on a special mission to Colombia, S.A., for the World Health Organization.

John B. Vasconcellos, M.D., has opened offices for the practice of Psychiatry in Catonsville and Glen Burnie.

George N. Austin, M.D., has been appointed Professor of Orthopedics and head of the division of Orthopedic Surgery at the University of Maryland School of Medicine.

John C. Krantz, Jr., was honored at a testimonial dinner on the occasion of his retirement as professor and head of the Department of Pharmacology of the University of Maryland School of Medicine.

J. Edmund Bradley, M.D., Professor of Pediatrics at the University of Maryland School of Medicine has recently retired after 31 years with the University.

George T. Nager, M.D., and Albert Steiner, M.D., have been elected President and Secretary-Treasurer of the Maryland Ear, Nose and Throat Society.

Robert A. Bier, M.D., Silver Spring, has been appointed consultant to the Council on National Security on matters concerning the Doctor Draft and its method of implementation.

John Sargeant

Executive Secretary

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Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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There is no one reason why people take up smoking and why the smoking habit develops. Likewise, there is no one treatment to cure the habit in all smokers.

The Vice of Smoking

GODFREY M. HOCHBAUM, PhD
Chief, Behavioral Science Section, Division of Community Health Services, USPHS

THE TITLE OF THIS SESSION, "Medical Aspects of Vice," intrigued me so much that I turned to Webster's Dictionary for the definition of vice.

Those of you who now smoke or have smoked until recently will be glad—or shocked—to learn that, according to Webster, you "indulge in degrading appetites" and are "in a state of being given up to evil conduct, depravity, and wickedness." And even Blakiston's *New Gould Medical Dictionary* describes you as being "in a state of depravity and immorality."

On the other hand, those of you who do not smoke can sit up proudly and bask in the knowledge that you are, to paraphrase Webster, clean, stalwart, and irreproachable members of the human race.

I hasten to confess to you that I, being a current pipe smoker, find myself in the first category, although being also a converted ex-cigarette smoker, I am, I suppose, no longer quite as wicked and depraved as I once was.

It is rather interesting that, at least at this session, the smoking habit should find itself associated with the vices of alcoholism and sex. Of course, it has certain characteristics in common with these.

Smoking can be rather pleasant—and so can drinking and sex. It is a habit that is easily acquired but hard to break—like drinking and sex. And it is a habit indulged in by many and condemned by many—just like drinking and sex. Finally, in smoking, as in the other two, social, psychological, and physiological forces interplay to such a degree that at times their relative contributions are difficult to separate.

Despite these similarities among the three vices which form the topics of tonight's session, there are also quite fundamental differences in respect to etiology, gratification and frustration of underlying needs, and their control.

Of the three, smoking appears to present the

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simplest problem. After all, there is only a limited choice of ways in which the need to smoke can be satisfied, compared to the variety of ways in which the need for alcohol can be indulged in and the almost infinite variations of sexual gratifications that one can find cataloged in textbooks on the pathology of sex. Also, people are much more likely to reveal truthfully and without too much inhibition their real smoking behavior than they are to reveal their drinking or, of course, their sexual habits.

For these reasons, one would expect that by now we understand the dynamics of the smoking habit better than those of the other two. Yet, this is not quite true. The smoking habit has, surprisingly, been far less subjected to scientific scrutiny than the others. Perhaps this is because it lacks the scintillating piquancy of sex, on the one hand, and has not represented as visible and disturbing a social problem as alcoholism, on the other.

Be that as it may, it was only in the wake of increasing statistical evidence in the late 1950's pointing to smoking as a major health hazard that social scientists began even to discover smoking as an attractive topic for investigation. But up to the appearance of the Surgeon General's report, no really topnotch social scientists (with a few notable exceptions) have carried out well designed research in this area. Most research has been amateurish or naive in conception and execution. As a consequence, there is relatively little truly scientific knowledge about the smoking habit but plenty of speculation, many firmly asserted but pseudo-scientific explanations, and a fairly large, but superficial and often misleading, body of statistical data.

Nonetheless, we can say certain things about smoking and about smokers, and we can draw a number of inferences from what we know, inferences that may have considerable bearing on ways in which we can help nonsmokers to remain in this "state of grace" and help smokers to regain it.

To begin with, all the evidence available to date points to two basic assumptions which we must make if we are to try to understand people's smoking behavior.

First, it is reasonably certain that the kinds of conditions or influences that prompt people to take up smoking are quite different from those that cause a person who initially smokes only occasionally to develop into a habitual smoker and finally into an addict.

Second, as physicians know full well, the existence of identical symptoms does not presuppose the existence of identical underlying disease. In the same way, the reasons why two people smoke are not necessarily the same just because the symptom—the smoking act—appears to be the same. Different people may smoke for different reasons; they may have started for different reasons; and they may try to satisfy different needs by smoking.

If you keep these two assumptions in mind, you will be skeptical toward anyone's claim that he has discovered *the* reason why people smoke. Moreover, as physicians know equally well, the same treatment is not necessarily indicated just because two patients have similar symptoms unless the underlying disease is also the same. Therefore, one must be equally skeptical when anyone claims that he has found *the* method or *the* technique that will help *all* smokers break their habit, regardless of the nature of the underlying conditions that account for their smoking behavior.

Why do people start smoking? A majority of smokers begin during their early or middle teens. It has been estimated that at the 12th grade level 40-55% of children smoke at least occasionally and 75% of later smokers will have developed the habit before the age of 18.

I had the pleasure of participating in the Children's Bureau's National Conference on Smoking and Youth, in which about 130 children between the ages of 12 and 20, representing all 50 states, took part. I was shocked to find that in one group of 12 boys and girls there were eight who now smoke fairly regularly, that four of them smoke about one pack a day, and that two smoke between two and two and a half packs a day. None of the children was over 17, and one was only 15.

In general, it appears that curiosity leads many children to their first experimentation; seeing others smoke, they become curious. Almost invariably they experience unpleasant sensations. Normally one would expect that this would prevent them from repeating the act. But at that time several powerful psychosocial forces come into play.

Among these, the most significant ones relate to the examples of parents, older brothers or sisters, and movie, TV, or athletic heroes who smoke. These examples, reinforced by advertisements, have created among our youth the image of smoking as a symbol of adulthood—of masculinity on the one hand and of femininity on the other. The very fact that the first cigarette proves distasteful, even sickening, seems, oddly enough, to reinforce this symbol. It is as though the unpleasantness of the experience dramatizes this turning point in the progress toward adulthood, much as the usually exceedingly painful puberty rites of primitive societies dramatize the entry of the young boy into manhood.

Some of the boys at the conference confessed that they smoke more when they are with older boys who smoke, especially members of the gang, or when they are on dates with girls, particularly when they feel unsure with the girl whom they take out. It is as though they were trying to impress their girl friends or the older boys and (probably more important) were trying to reassure themselves that they are men.

At the same time that smoking begins to serve this purpose, it may also begin to serve another. Sometimes consciously, sometimes unconsciously, it expresses a rebellion against authority. The very fact that smoking among children is frowned upon by adults makes it an expressive means of demonstrating a rejection of this authority vested in the older generation. I suspect that the popularity of certain singers among teenagers symbolizes the same kind of rejection of the older generation. Thus I am struck with the fact that almost invariably those singers most popular with teenagers are the very ones that are most obnoxious to us grownups. If this interpretation is correct, then the adoration of their singer idols by teenagers may serve a purpose similar to that served by cigarettes.

Subsequent to the Surgeon General's report many schools have prohibited smoking on their grounds and have removed the privilege of smoking in rooms previously set aside for this purpose. If—and there is considerable research evidence to support this hypothesis—cigarettes represent symbolic rebellion against adult authority, then this kind of authoritarian prohibition not only would be ineffective but could actually further stimulate smoking as a means of protest.

This is a good illustration of the need to appreciate the underlying motives for smoking among adolescents in order to evolve effective means to curtail it rather than to come up with ready made pat prescriptions.

In any case, we can say that most children slip into the smoking habit by following the example of older children and of adults and as an expression of rejection of adult authority.

I use the term "slip into the habit" deliberately. For smoking as a habit has an insidious beginning. It starts out with an occasional cigarette, perhaps one a week, but slowly the frequency increases to two or three a week, one a day, and so forth. As this frequency increases, new psychological forces are activated. Thus, the act of lighting a cigarette becomes associated with certain other events and conditions. For example, a person may get into the habit of taking a cigarette every time he drinks coffee or every time he faces a difficult task or every time he enters a room with people or every time he talks to someone on the phone.

What occurs is similar to the conditioning involving Pavlov's famous dogs. In Pavlov's experiments a bell was rung every time he presented his dogs with food. After many simultaneous presentations of the sound of the bell and the sight of the food, these two stimuli became associated. Eventually the dogs began to salivate when they heard the bell, even in the absence of food.

In a similar way, when a person develops the habit of lighting a cigarette, say, every time he sits down to a cup of coffee, these two acts become associated. The more often this happens, the more powerful becomes the need to smoke while drinking coffee. Thus, each cup of coffee set before such a person excites an intensive desire for a cigarette, almost like a reflex response.

Every smoker, particularly a heavy one, forms many such associations. And a powerful need to smoke is created every time he carries out an act or faces a social situation that has become associated with smoking. The lack of cigarettes in such situations becomes almost unbearable.

This, then, is what happens: An adolescent may have taken his first cigarette out of curiosity; subsequently, he proceeds to smoke in earnest, perhaps, to demonstrate his masculinity and adult status even though his curiosity has been satisfied.

A few years later, having become an adult himself and no longer needing to demonstrate this fact, he needs to smoke partly because it has become a deeply entrenched habit, tied up and associated with many other daily acts, events, and mental states.

Thus we see that the psychological forces that accounted for the taking up of smoking in the first place have been supplanted by other psychological forces, often unconscious, much more insidious, and much more powerful. It is also quite obvious that steps that need to be taken to reduce smoking by confirmed smokers will have to be different from steps to be taken to reduce smoking by persons whose habit is of relatively recent origin.

That the criterion here is not so much the age of the smoker as the degree to which the habit has become established in him, was driven home to me dramatically at the conference on youth and smoking. One girl, only 17 years old, sought my help with her smoking problem. She confessed to smoking more than two packs a day. With tears in her eyes she told me how terrified she was of getting cancer and how desperately she wanted to quit. And this girl, only 17 years old, had tried again and again to quit, but had failed each time.

It is difficult for the nonsmoker to understand and appreciate the grip of the smoking habit. A few years ago, in connection with a study on people's health behavior, we tried to establish the frequency with which people carry out certain habitual health acts, such as toothbrushing, washing one's hands, and others. One purpose was to learn whether this frequency was related to people's resistance to attempts to change such habits. Simple arithmetic showed that a smoker who consumes, say, two packs a day, that is 40 cigarettes, goes through the act of lighting a cigarette—14,240 times a year. I do not know how many puffs he takes from any one cigarette, but let us estimate it to be 20 (possibly a conservative estimate). This means leading a cigarette to his mouth and inhaling its smoke nearly 300,000 times a year. There are few other voluntary acts that man carries out and repeats that often.

Even if we disregard any physiologic cell adaptation that may develop—that is, true pharmacologic addiction—it is still no wonder that smoking often becomes one or perhaps *the* most deeply ingrained of all habits.

It is this powerful sway that the smoking habit holds over most smokers that has led psychologists and psychiatrists to postulate some deeper psychological dynamics. For example, psychologists have searched to identify what is commonly referred to as "the smoker personality." It has been proposed variously that smokers are primarily extroverts, that they tend to have certain neurotic traits, that they are characterized by more tension, by anxiety states, and by psychosomatic manifestations. There is some evidence that cigarette smokers do tend toward the extrovert end of the introvert-extrovert continuum and that some neuroticism is indeed associated with the smoking habit. However, none of this evidence is altogether convincing.

Some psychologists have suggested that there is an element of self-punishment or, as some psychoanalysts would conceive of it, a death wish, in smoking. It has been pointed out that heavy smokers frequently increase their consumption of cigarettes as they become more and more convinced of the danger to which they expose themselves. This phenomenon could, however, be explained in other ways, so that no firm position can be taken on the basis of our present insufficient research data.

Psychoanalysts have interpreted smoking as being related in various ways to sexual drives. Thus, cigarettes—and even more so cigars—have been regarded by some as phallic symbols with rather obvious inferences as to the kind of needs that are being satisfied by the smoking act. Others have advanced the hypothesis that smoking, like thumbsucking, is a regressive oral activity related to the infant's pleasure at his mother's breast. It has been claimed that male thumbsuckers are likely to smoke (and drink) in later years. It has indeed been found in at least one study that smokers who have been weaned of the mother's breast relatively late tend to find it easier to break the smoking habit than those who have been weaned earlier. Still, the evidence is insufficient to either accept or reject such psychoanalytic hypotheses.

The sad fact is that there is no single theory that can account for the smoking habit in all of its various manifestations.

Perhaps the best evidence for this state comes

from the experience with various attempts to discontinue smoking. If, to take one theory, it is the oral activity, the gratification of oral sexual needs that accounts for the smoking habit, then we would expect that any cigarette substitute which provides for the same kind of oral activity would de facto serve as an effective substitute. However, artificial gadgets, shaped like cigarettes but allowing only for inhalation of air which passes over fragments of menthol have proven quite ineffective. And most confirmed cigarette smokers who have shifted to cigars or pipes know that such a shift is virtually as difficult as complete cessation of smoking, at least for quite some time.

Similarly, if we accept the theory that smoking is a psychological mechanism to reassure a teenager of his adult status, the habit should become weaker rather than stronger with advancing age. The fact that we observe the converse shows that this theory, taken alone, cannot account for the habit anymore than can the psychoanalytic theory, taken alone.

If we accept as a premise that different smokers smoke for different reasons and to satisfy different needs, then, as I said earlier, the search for one single psychological characteristic to account for *all* smoking behavior must be as futile as would be a search for one single kind of abnormality to account for all heart disease. Probably several theories are needed, each explaining smoking behavior of some smokers or explaining some dimensions of this behavior in any one smoker.

I hasten to add that I have deliberately omitted any reference to the pharmacologic aspects of smoking. Being a psychologist myself, I do not feel competent to discuss these aspects. However, as the Surgeon General's report indicates, there is evidence that habituation in the area of smoking has indeed a pharmacologic basis. There is evidence that smokers, even when they consume comparable amounts of cigarettes, differ from one another in the degree to which they become pharmaceutically habituated to nicotine. Why this should be so and what the implications are in respect to discontinuance of the habit is still in the realm of controversy. In any case, cell tolerance and adaptation to nicotine only develop with prolonged use. The onset of the habit and its early intensification must logically be due to psychological and social factors. Only at some later stage of psychological habituation does pharmacological habituation come into play. This is another reason why different steps toward helping a smoker to discontinue are indicated, depending on how long he has been smoking and depending on his personal characteristics as well as those of his habit.

This leads me finally to the question: what can we do about the smoking problem? In view of the difficulty of breaking the habit, the best solution appears to lie in the development of a "safe" cigarette. I am afraid, however, that if this comes to pass at all, it is still a long way off.

It is not merely a matter of overcoming mechanical and chemical problems. There are, to make matters worse, indications that cigarettes with appreciable amount of nicotine or tars removed fail to satisfy the smoker. He may refuse to buy them, or he may compensate by smoking more cigarettes or by inhaling the smoke more intensively. Hence there is some doubt that so-called "safe" cigarettes will become popular among really confirmed and habituated smokers. They may, however, find acceptance by many young smokers who have not yet become habituated to traditional cigarettes.

If we cannot pin too much hope on a speedy development and popularization of "safe" cigarettes, we must fall back on attempts to change the habit itself. And such attempts involve three distinct problems: how to prevent nonsmokers from becoming prey to the habit, how to help smokers break it, and how to help exsmokers to abstain permanently. The last of these may well be the most difficult.

It would carry me too far afield to go into the many and complex ramifications of these problems and of ways of dealing with them. The fact is that there is no single answer, no single solution, no single method or technique known to date. It can be safely said that any one of the large number of methods now used, with or without the adjunct of various drugs, will help some smokers, but none will help all or even a majority of smokers.

This places the practicing physician in an awkward position. He is one of the persons whose advice is most frequently sought by smokers who wish to stop. And, of course, he is the one who frequently must advise a patient to do so. Yet, as often as not, he can do little more than exhort the

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patient and try to make the patient's ordeal a bit easier by prescribing some drugs of doubtful effectiveness.

At this point of our knowledge, smoking, like any disease, requires careful diagnosis. But, involving psychological and social problems, this diagnosis must take into account the smoker's personality, the nature of his personal habit, and his social relationships with his family and others (especially if any of these should be smokers themselves), as well as his medical status. And just as is the case with any disease, the treatment must be adapted to the individual patient. Any standard technique or combination of techniques that is applied to all smokers indiscriminately will, to be sure, work with some but will fail with most.

Although many doctors could probably diagnose the problems that may underlie a patient's compulsory smoking habit, certainly few have the time (and perhaps the know-how) to carry such a patient along the tedious and time-consuming path toward a complete cure of the habit.

One solution that is being tried is the establishment of community "smoking clinics" to which the physician can refer his patients. Unfortunately, most existing smoking clinics are haphazard affairs, conceived and managed with much enthusiasm and dedication but with little understanding of the underlying problems. Their methods are based on hunches, albeit clever ones at times. Yet, although we are still largely groping in the dark, there is a considerable body of knowldge on the nature of habits that has accumulated from psychological research. We cannot afford to disregard this knowledge. If clinics are set up, they should be staffed by properly trained professional personnel who develop methods with a scientific approach and who are willing and capable of scientific research aimed at developing more effective methods and of evaluating these.

Perhaps the best contribution that physicians could make at this time, would be to lend the considerable weight of their influence to the establishment of such properly staffed and truly professional smoking clinics.

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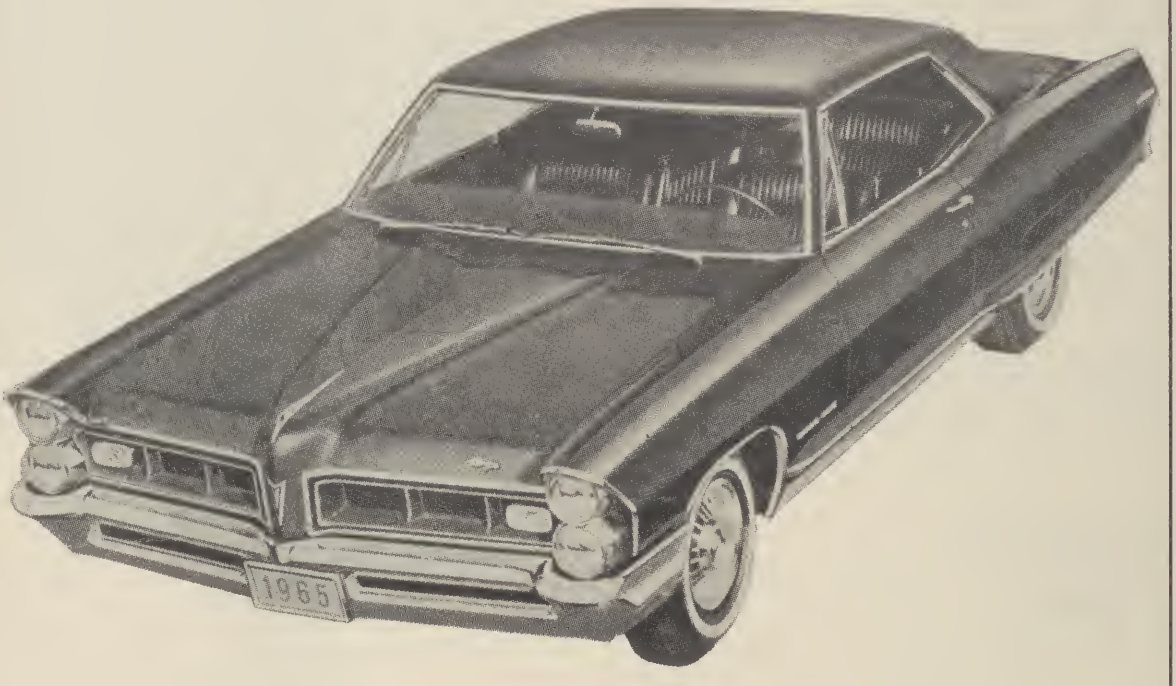
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The most satisfactory means of restoring circulation in the lower limbs of patients suffering from obliterative arterial disease is saphenous vein bypass autograft from the common femoral artery to the popliteal artery. Neither synthetic grafts nor endarterectomy have proven as satisfactory. Ten requirements must be observed for a successful reconstructive arterial procedure.

Some Recent Advances in Surgical Procedures for Treatment of Obliterative Diseases of the Major Arteries

ROBERT R. LINTON, MD

I WOULD LIKE TO EXPRESS my appreciation for being asked to give the Trimble memorial lecture this afternoon and to join the group of distinguished men in medicine and science who have preceded me in giving these lectures. I unfortunately did not have the opportunity of knowing Dr. Trimble; and how more unfortunate it was that the antibiotics were not available at the time of his last illness, since I am sure his life could have been spared with them. It is worth pointing out at this time that without these wonder drugs I undoubtedly would not be here to give this lecture, because it is in great part only from their use in preventing postoperative infections that it is possible to perform the long and meticulous operations which are necessary in many cases to restore the circulation in patients with obliterative arterial disease.

The subject for my talk is recent advances in reconstructive surgical procedures for obliterative diseases of the major arteries of the lower limb. I shall limit my remarks to those blood vessels carrying blood to the lower limb, but I would like to point out that the principles of treatment which I will describe apply to all major blood vessels elsewhere in the body.

This is a new field in surgery that has developed for the most part during the past decade. I became interested in peripheral vascular diseases in the early 1930's because there seemed to be much that could be accomplished for the unfortunate person suffering from obliterative arterial disease of the lower extremity, too frequently then ending in major amputations. For a number of years we performed lumbar sympathectomies, which did help some of the patients, but this type of procedure left much to be desired in many of them. It still offers some patients improved circulation to the feet when the reconstruc-

I. Ridgeway Trimble Fund Lecture, presented May 6, 1964, at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

From the Department of Surgery, Massachusetts General Hospital, Boston.

tive procedures cannot be carried out and for that reason should not be discarded. More conservative methods were necessary for many of the patients so that it was necessary to resort to postural exercises which, if carried out properly, did give some relief.

If I had been told 12 or 15 years ago the type of operative procedures that I am performing today in this field, I would have said they are impossible, especially those to restore the circulation in a limb with impending gangrene secondary to severe obliterative arterial disease. I shall describe some of the methods that we use today which will restore the arterial blood supply to the limbs of most patients, even with severe obliterative arterial disease, and demonstrate that nothing seems to be impossible in surgery and it is important to keep an open mind in regard to new procedures that may offer relief to the human sufferer.

The chief indication for performing reconstructive surgery on the arteries of the lower extremity is to save a patient's extremity from amputation. Ischemic ulcers of the toes and foot, even the lower leg, which result in extreme rest pain can often be healed and the pain eliminated by this newer type of surgery. A few years ago the only alternative was to amputate the extremity, in many cases above the knee.

A second indication, and one which I see more frequently, is that of intermittent claudication on exercise. Many patients are referred to me who can only walk one or two blocks because of pain in one or both calves and then have to stop and rest before they can go on further. Often they can learn to live with this handicap since they are in no jeopardy of losing their limb because of a good collateral blood supply and, as a result, no ischemic lesions. Some patients, such as postmen, find that this condition interferes with their livelihood, but most patients complain that this handicap limits their walking to short distances of 50 or 100 yards. It is my opinion that with reconstructive arterial surgery the great majority of these patients can be rehabilitated and their intermittent claudication completely relieved.

Another indication is that with reconstructive arterial surgery an amputation may be done successfully at the site of election below the knee, thus saving the knee joint, whereas without it it would be necessary to do one above the knee. It permits the salvage of part of the limb which otherwise would have to be sacrificed.

Table 1

REQUIREMENTS FOR A SUCCESSFUL GRAFTING PROCEDURE FOR OCCLUSIVE ARTERIOSCLEROSIS OF MAJOR ARTERIES

1. **Accurate arteriograms**
2. **Available venous autografts**
3. **Adequate arterial inflow**
4. **Adequate arterial outflow**
5. **Prophylactic antibiotics**
6. **Heparin**
7. **Multiple transfusions**
8. **Meticulous technique**
9. **Non-shock type of anesthesia**
10. **Adequate time and patience**

I would next like to discuss what I consider to be the 10 requirements necessary for successful reconstructive arterial surgery in obliterative arterial disease (Table 1). The first is that you must have accurate arteriograms, especially in those patients with a block of the femoral artery, as it is impossible to carry out successful reconstructive surgery without them. It is my opinion, furthermore, that the surgeon who is to do the reconstructive procedure should perform the arteriograms or have one of his assistants do it rather than rely on the radiology department. In our hospital, the best method is to perform them in the operating room using a portable x-ray machine and preferably having one x-ray technician assigned for these procedures. It is scheduled as an operation so that one can be sure of when it will be possible to do it and, furthermore, all materials necessary to do the arteriogram will be available. I have found that the best method of visualizing the femoral, popliteal, and outflow vessels from the latter artery is to use a large amount of dye and take a relatively slow x-ray exposure. My routine, therefore, is to use 50 cc of 60% meglumine diatrizoate (Renografin) which is injected over a period of 15 seconds, at the end of which time the x-ray exposure is made. This is a one and one half second exposure at 70-80 kv. With this technique good visualization is obtained routinely of the distal femoral artery, the popliteal artery, and its outflow vessels if there is a block of the superficial femoral and popliteal arteries.

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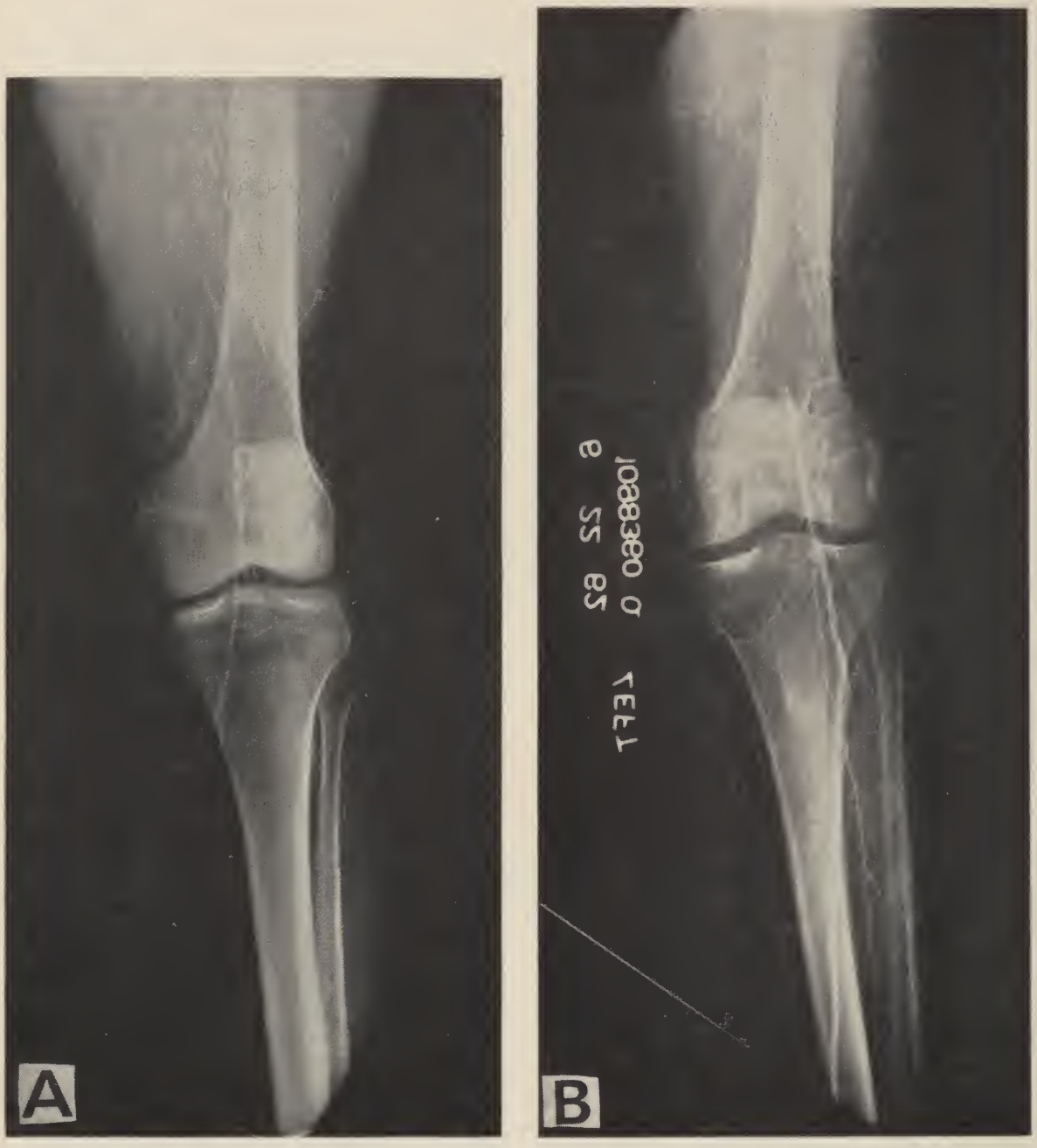


Fig 1

A. A left femoropopliteal arteriogram of a man, age 59, performed in 1960 with the wrong timing. The popliteal and outflow arteries are not visualized. As a result it was believed the arteries could not be reconstructed.

B. A left femoropopliteal arteriogram of the same extremity performed two years later because of increasing symptoms and signs of arterial ischemia. This arteriogram was performed with the correct timing. It demonstrates that despite an advance of the patient's disease the popliteal and outflow arteries are patent so that the arterial condition could and was reconstructed by insertion of a saphenous vein bypass autograft.



Fig 2

A portion of a dacron-teflon femoropopliteal bypass prosthesis removed three months after it had been implanted in a man, age 49, because of graft failure from occlusion. Note the thick layer of fibrous tissue around the cross sections of the specimen which produces marked rigidity and loss of elasticity in the prosthesis. It is believed that this fibrous tissue growth is one of the chief causes of failure of the synthetic grafts in the lower extremity, especially when they cross joint areas.

lowed when an arteriogram was done on one of my patients, I decided that I could not do a reconstructive procedure on his leg because the popliteal artery was not visualized (fig 1a). At that time he was complaining of intermittent claudication, but during the next two years his symptoms became worse. He returned stating that he couldn't walk as far as he could two years ago and was beginning to have rest pain at night. I readmitted him to the hospital and performed the arteriogram myself according to the technique described, and much to my surprise and relief, I found that he did have quite a satisfactory popliteal artery and outflow vessels so that I was able to put in a saphenous vein bypass graft and relieve him of his intermittent claudication and rest pain (fig 1b). In summary, then, it is my opinion that for satisfactory femoropopliteal arteriograms a large amount of dye and a relatively long x-ray exposure are necessary so that sufficient time is given to fill the popliteal artery and the outflow vessels through the collateral blood supply.

A second requirement is that one must have available a satisfactory graft to restore the arterial continuity for obliterative atherosclerosis of the lower extremity. It is my opinion the synthetic prostheses should not be used because they have such a high percentage of early failure. The most satisfactory graft, without any question, is the patient's own saphenous vein. In my experience, approximately 80% of patients have a vein which is of large enough caliber to use. The next best choice, in those who do not have a vein that can be used, is an endarterectomy of the femoral and popliteal arteries, using vein patch grafts at the site of the arteriotomy incisions.

Ten years ago I wished I had a crystal ball that I could look through to see what we would be doing 10 years from then. Ten years have passed and it is possible now to look back and see some of the mistakes we made. Without any question one was the use of arterial homografts. These functioned satisfactorily when implanted, in fact they were the most successful of all grafts for

immediate good results, but after two or three years a great many of them became aneurysmal and others became thrombosed. Consequently, this type of graft has been given up because of the high rate of late failures.

One of the early prostheses that we used was made from ivalon. The graft could be made in the operating room and fashioned to the needs of the patient, but unfortunately none lasted more than a year as they all became occluded from dislodgement of the pseudo-intima with embolism of the distal arteries, and the tube of ivalon became a rigid pipe. I only put six of these in, as they all became occluded.

Since then various types of synthetic grafts have been developed. The most common in use today by other surgeons are made of dacron and some of teflon, but all have a high late failure rate. It has seemed to me that the main cause of failure of these synthetic grafts is the tremendous fibrous reaction of the host to them (fig 2), which makes them very stiff and rigid so that when the hip and knee are flexed they tend to buckle and kink and finally occlude (fig 3a). This is especially true when the graft crosses the knee joint. With a saphenous vein autograft, on the other hand, one sees a general curve during genuflexion (fig 3b) instead of the acute kinking that occurs with the prosthesis.

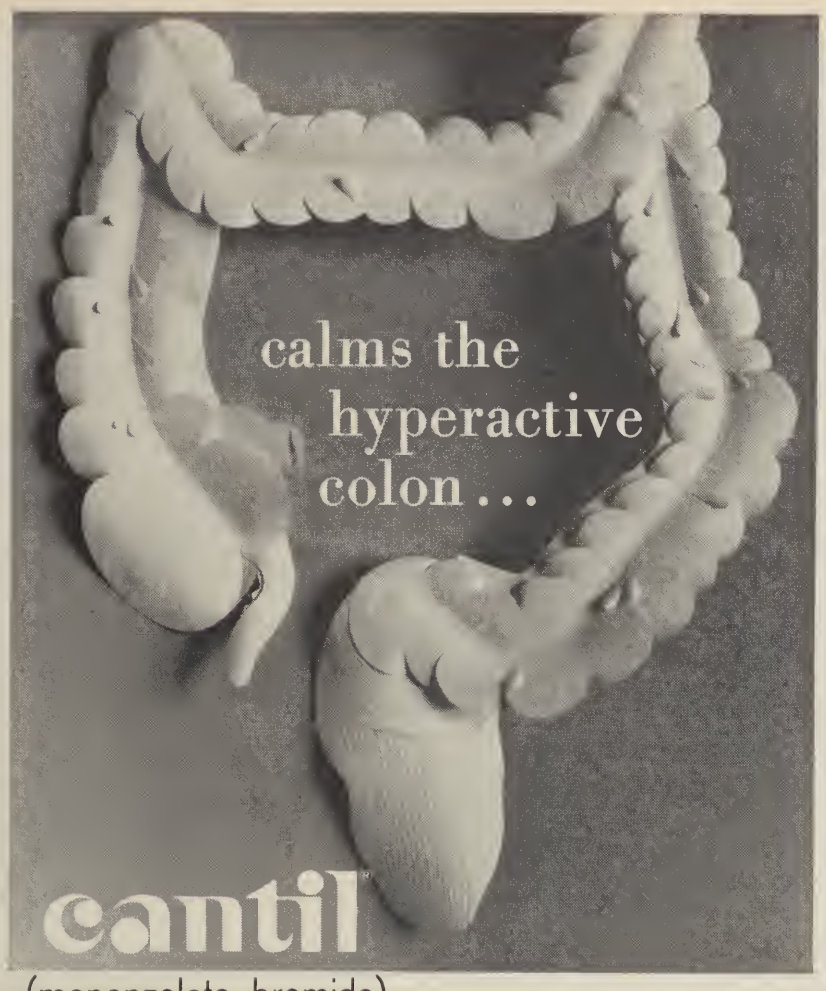
Without question the saphenous vein autograft is the best arterial replacement that one can get for occlusive disease of the femoral artery in the thigh. In some instances, because the saphenous vein may not be of large enough caliber throughout its length or it has been removed previously, it is necessary to combine a saphenous vein autograft with an endarterectomy. The most satisfactory size for a saphenous vein is 5 to 6 mm in diameter. It is possible to use 4 mm ones if exquisite technique is used; at the other extreme, a 7 mm one probably is not too large.



Fig 3

A. A femoropopliteal arteriogram in a man, age 53, showing a dacron-teflon prosthesis still patent after five years. Note the kinking, however, with the knee flexed to 90 degrees, the result of the loss of elasticity in the graft secondary to the marked fibrous tissue reaction around it.

B. A femoropopliteal arteriogram in a man, age 61, showing a saphenous vein autograft still patent after five years. Note the gentle curve of the graft without kinking with the knee flexed to 90 degrees. This characteristic of venous autografts is without question one of the reasons this type of graft is superior to the synthetic ones.



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Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

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- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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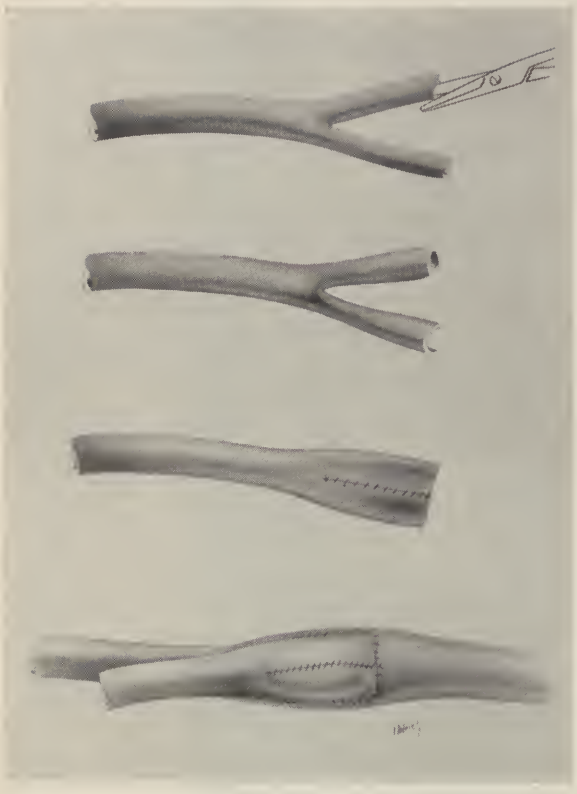
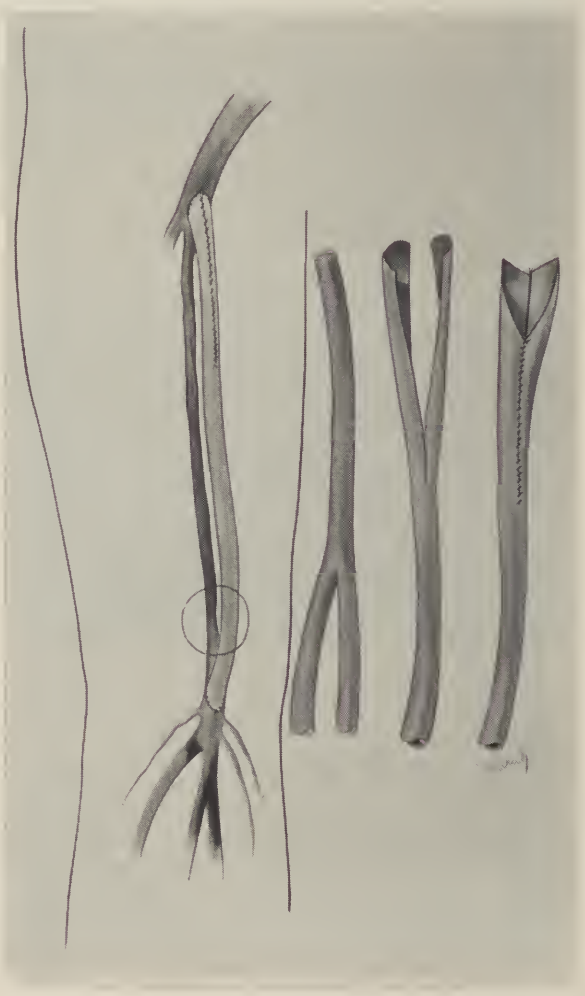


Fig 4

An artist's drawing showing an angioplastic procedure between two branches of the distal end of a saphenous vein autograft. This is performed in order to make a larger cuff of vein so that a wider proximal anastomosis can be constructed, thereby resulting in a better inflow into the graft. This method is especially useful when a thick friable intima is encountered in the proximal artery.

Fig 5

An artist's drawing of a long angioplastic procedure to a bifid saphenous vein in a man, M.L. aged 73 years. Neither branch was large enough in diameter to make a satisfactory graft. A long single lumen venous autograft was constructed after incising each branch longitudinally by suturing them together except for a short distance on one side to make a cuff for the proximal anastomosis.



A third important requirement for a successful reconstructive arterial procedure is that one must make certain that there is an adequate arterial inflow from above into the graft. This factor, I believe, has been overlooked by many surgeons working in this field and explains many of the failures. In my experience, the inflow to the graft is far more important than the outflow. One can usually determine by the quality of the pulse and the character of the artery to palpation at the site chosen for the proximal anastomosis whether there is going to be adequate inflow into the graft. After opening the artery I often release the occluding clamp to see what type of a jet stream of blood comes out of the proximal artery. If it does not come out with considerable force, it means that I must go higher to get a better flow of blood from above. This may mean doing an endarterectomy of the iliac artery or, in some cases, even going as high as the terminal aorta itself.

In addition, in order to get a better inflow into the graft through the proximal anastomosis, I frequently do an angioplastic procedure on the distal end of the saphenous vein which is used for the proximal anastomosis. The vein is dis-



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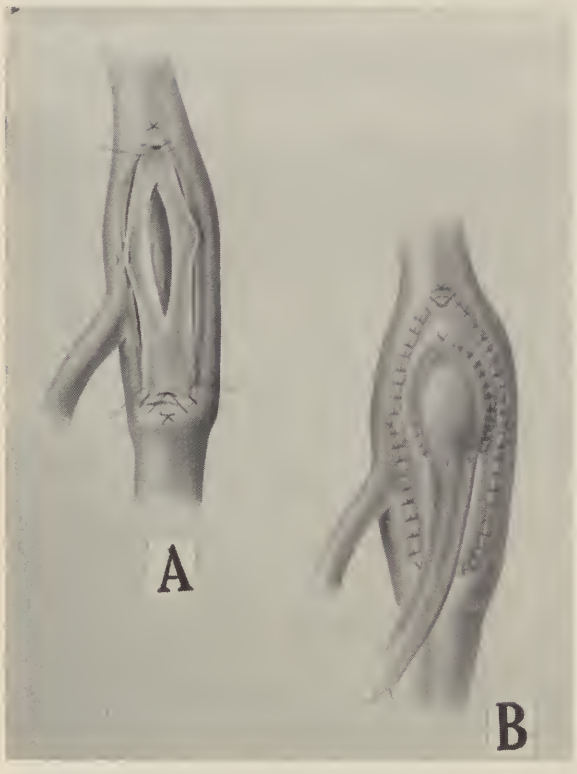


Fig 6

An artist's drawing to show the proximal anastomosis made to a venous patch graft in the common femoral artery at the origin of the profunda femoris artery. This method is used when the common femoral artery is very thick-walled, in order to permit the construction of a better anastomosis of the venous autograft to the thin wall of a venous patch graft. A. The patch graft is being placed. The incision in it after the implantation of it is completed. B. The completed proximal anastomosis of the saphenous vein bypass autograft to the venous patch graft in the common femoral artery.

sected distalward until a major bifurcation is encountered, which is usually just below the knee. At least two centimeters of these branches are removed with the main saphenous trunk. These two branches are then incised longitudinally and the opposite cut edges of each are sutured together; this gives a much wider cuff of vein with which to make the proximal anastomosis and thus insure a better inflow from the host artery into the graft (fig 4). Occasionally the saphenous vein may be bifid for a considerable distance and neither of the branches will be large enough with which to make a graft and construct the proximal anastomosis. In this case the branches are incised and sutured together as a single tube for the greater distance, leaving a small portion sutured only on one side to make a good cuff for the anastomosis. In this way one can utilize a saphenous vein which otherwise could not be used and get an excellent inflow into it by such an angioplastic procedure (fig 5).

Another method that is helpful when the common femoral artery is a thick walled one, which makes an anastomosis difficult to construct, is to suture a vein patch graft into the arteriotomy site of the femoral artery and then make the proximal anastomosis of the saphenous vein graft to the vein patch graft. This method also insures an excellent inflow into the graft which might otherwise be compromised by the thick intima of the femoral artery if a patch graft were not utilized (fig 6).

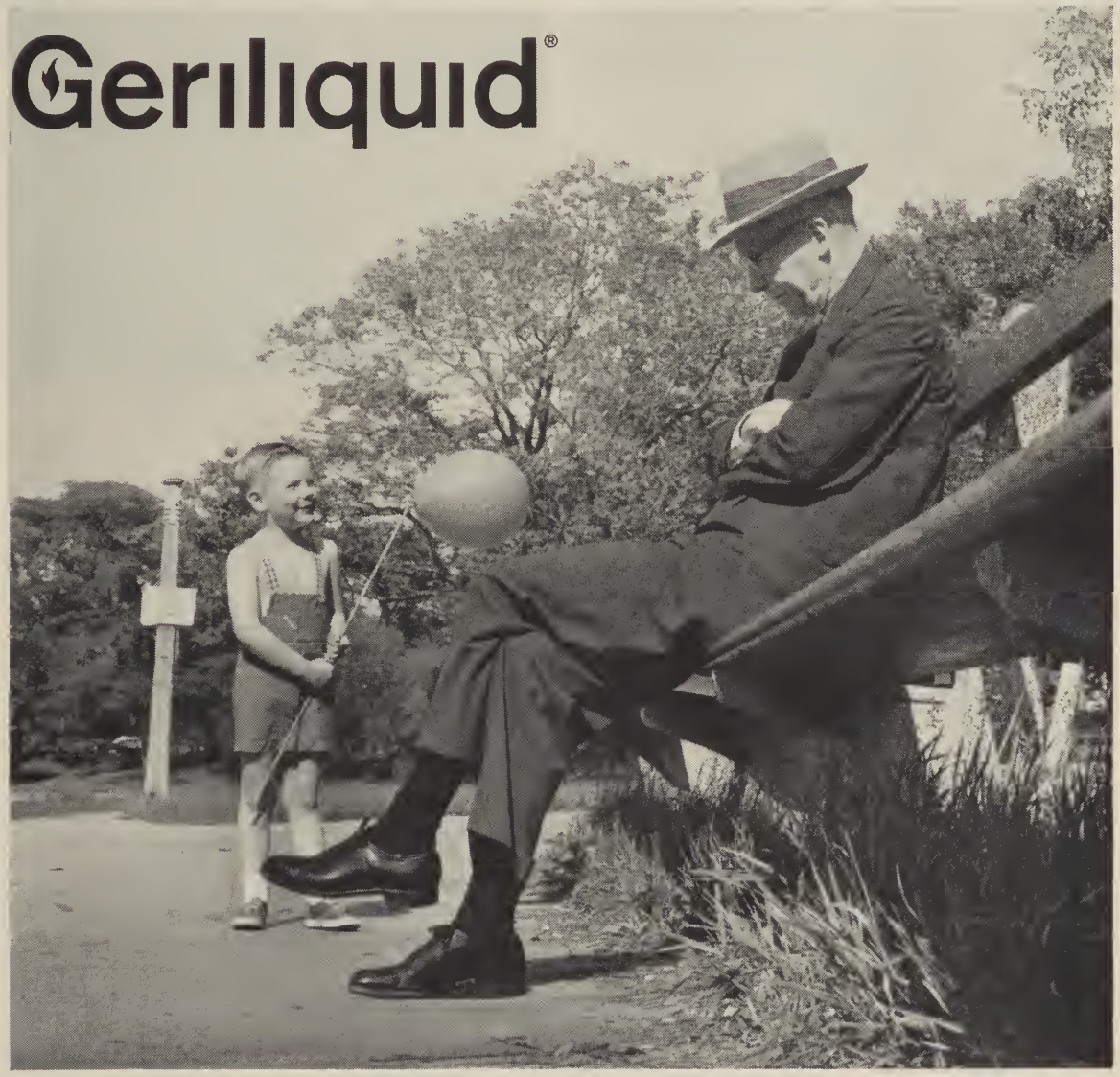
Many surgeons consider the outflow from the popliteal artery of great importance when evaluating the chances of a successful result. I have usually classified the outflow as follows: a patent popliteal artery with patent posterior tibial, anterior tibial, and peroneal arteries as excellent; a patent popliteal artery with two of the branches open as good; a patent popliteal artery with one branch open as fair; and a portion of the popliteal artery open to which I can implant a graft but none of the major branches open but some collateral branches coming off it which are open, as a poor outflow tract. In my opinion, an excellent outflow from the popliteal artery is desirable but not necessary for a successful grafting procedure. Sometimes only one of the three outflow arteries may be open, and in some cases the geniculate arteries may be the outflow tract, which does not preclude getting a good result from the implantation of a saphenous vein autograft providing one

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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

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Fig 7

A. A right femoropopliteal arteriogram showing a badly diseased popliteal and poor outflow arteries from it in a woman, age 79, with severe ischemia and a line of demarcation developing at the mid lower leg.

B. A postoperative femoropopliteal arteriogram in the same patient performed nine weeks after implantation of a 45cm saphenous vein femoropopliteal bypass autograft. Note the improvement in the distal popliteal and outflow arteries. The extremity was saved and the patient is alive and doing well, now two years and four months since the grafting procedure. It is doubtful that any other type of reconstructive procedure would have been as successful.

makes certain that there is a good inflow of arterial blood coming from above.

It has been my experience that a successful grafting procedure with a saphenous vein autograft can be performed providing one has a patent portion of the popliteal artery to which a saphenous vein can be anastomosed. In some instances the length of the popliteal artery that is patent may be only 2 or 3 cm, but frequently one can find in it a relatively soft, thin-walled area to which a graft can be anastomosed (fig 7a). These will usually function despite the extremely poor outflow and limbs can be saved (fig 7b). Under these conditions, however, it is of utmost importance that the inflow be of the best quality.

A fifth requirement is prophylactic use of the antibiotics, which means they must be administered before the operation is commenced. One should not wait until the operation is completed because then wound contamination may have already occurred. I routinely administer 600,000 units of penicillin and one quarter of a gram of streptomycin when the patient is put on call to the operating room. If the operation takes from 10 to 12 hours, as frequently they do, additional antibiotics in the same dosage are given six hours after the previous administration. In addition, the patient is given one gram of erythromycin (Ilotycin) intravenously during the operative procedure. The same antibiotics are continued postoperatively, usually for five days, and then discontinued unless there seems to be some reason

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to Iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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that they should be administered longer. It is my opinion that without the proper use of the antibiotics in this manner it would be impossible to carry out safely these long operative procedures where infection, if it occurs, can be lethal so quickly.

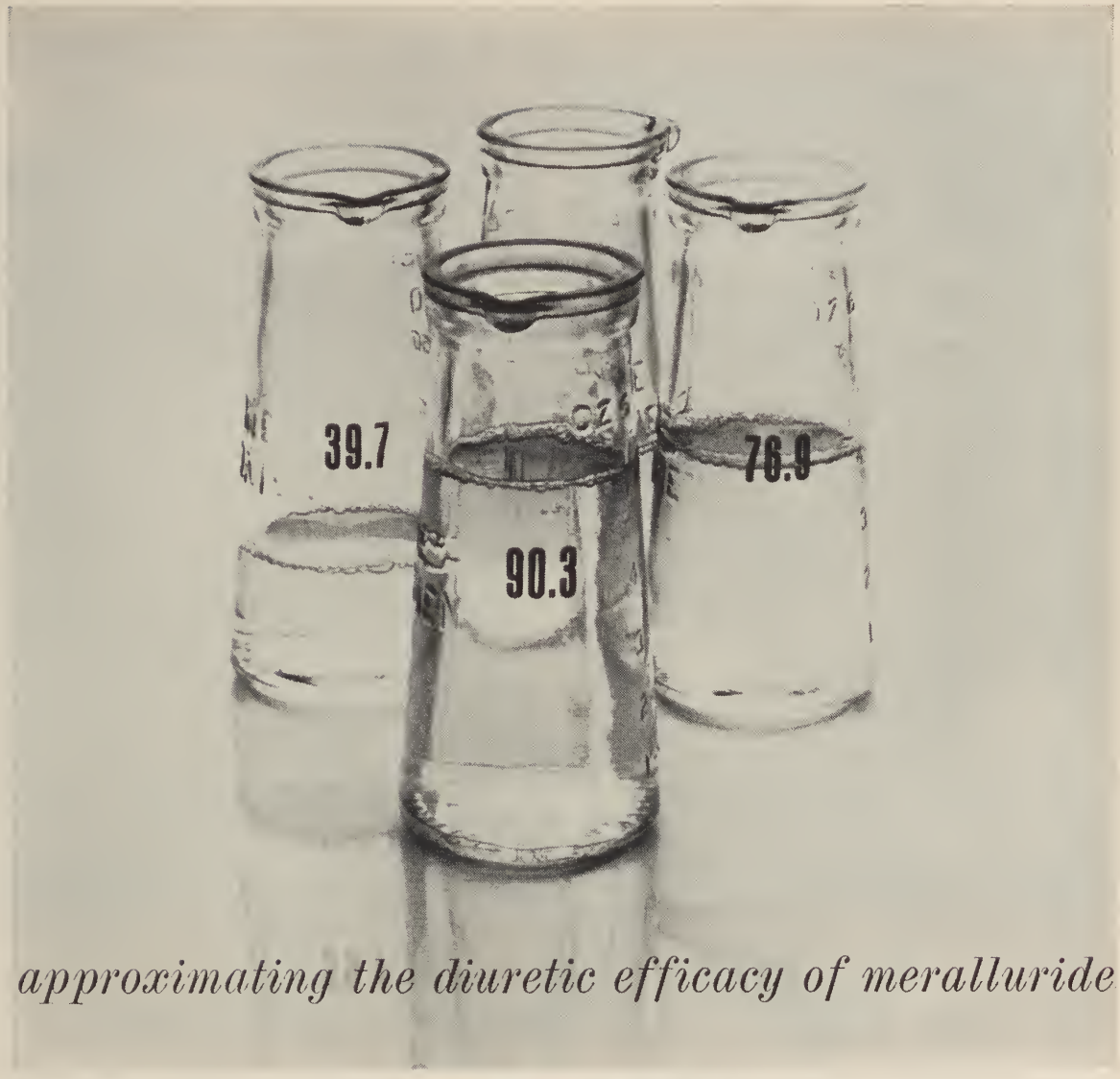
The sixth requirement, and almost as important as the antibiotics, is the use of the anticoagulant heparin during the operative procedure. I do not believe it would be possible to carry out these long reconstructive operations without it, because while the arteries are occluded during the process of constructing the anastomoses and doing the endarterectomies that are necessary, secondary clots could form distal to the occluding clamps if heparin is not given. It is my custom to fully heparinize the patient approximately 10 minutes before occluding the major artery that is going to be reconstructed, whether this be the aorta, iliac, femoral, or popliteal artery. I, personally, inject the heparin myself to make certain it is administered. For the average patient, 40 mgm is given intravenously into the largest vein that one can find to make certain that it gets into the blood stream. This amount of heparin will usually last four to five hours. Sometimes it is necessary to repeat it if the operation is prolonged. In addition, a dilute solution of heparin, 1mgm/5 cc of normal saline, is given through a small polyethylene tube into the artery beyond the distal occluding bulldog clamp, especially if I am concerned about a roughened and ulcerated intima on which a blood clot might develop and occlude the artery distal to the graft, resulting in failure of the graft. Once the artery has been reconstructed by successfully implanting a venous autograft, no further anticoagulation is administered. I believe one should construct the proximal and distal anastomoses so perfectly that there will be an excellent flow of arterial blood through the graft, thus avoiding the necessity of additional anticoagulation. Furthermore, I do not believe the postoperative administration of heparin will salvage a poorly done procedure.

The seventh requirement is the use of multiple blood transfusions. Occasionally only one or two transfusions will be necessary, but more frequently five or six are required, and occasionally 10 to 15 have been necessary. It is absolutely essential, therefore, that sufficient blood be available in the blood bank to take care of any blood loss that may occur. This sometimes develops from every capillary and small blood vessel in the operative field. It is operative complications such as this that make me think that this type of surgery should be done only in the larger centers, where ample blood is available, rather than being attempted in small community hospitals except in dire emergencies.

The eighth requirement is that meticulous technique for this type of surgery is absolutely essential. I believe most failures are the result of technical errors. At least I am sure this is true in most of my own cases that have failed. Before attempting this type of surgery, every surgeon should acquaint himself with the requirements of careful meticulous blood vessel anastomoses and develop the ability to dissect out the fragile saphenous vein and preserve it intact so that it can be implanted as a long tube without having to make repairs on it because of inadvertent lacerations during its removal.

The ninth requirement is that one must have an experienced anesthesiologist who can administer an anesthetic over a long period of time without its affecting the patient's blood pressure. It must be a shockless type of anesthesia. In my experience this has been induction with intravenous pentothal, the use of a muscle relaxant and gas-oxygen administered through an endotracheal tube, and, if necessary, supplemented with a little ether. It is of utmost importance that the patient's blood pressure be maintained at a normal level without the use of vasoconstrictive drugs; only in this way can one get an adequate inflow of blood into the reconstructed arteries.

The tenth requirement is that one must have sufficient time and patience to carry out these long, meticulous procedures. I never look at the clock once the operation is started until it is finished; I never try to hurry to get through to do something else. These are important jobs to be done, and they can only be performed if one has adequate time and patience. If these rules are followed, the instances of reoperation because of failure of the reconstructive procedure, usually due to thrombosis, will be extremely small. In the long run one will save an infinite amount of time and energy by taking a little extra time and care at the initial procedure. An arteriogram should be performed as soon as the graft is functioning in order to check the anastomoses, so that if a defect



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To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

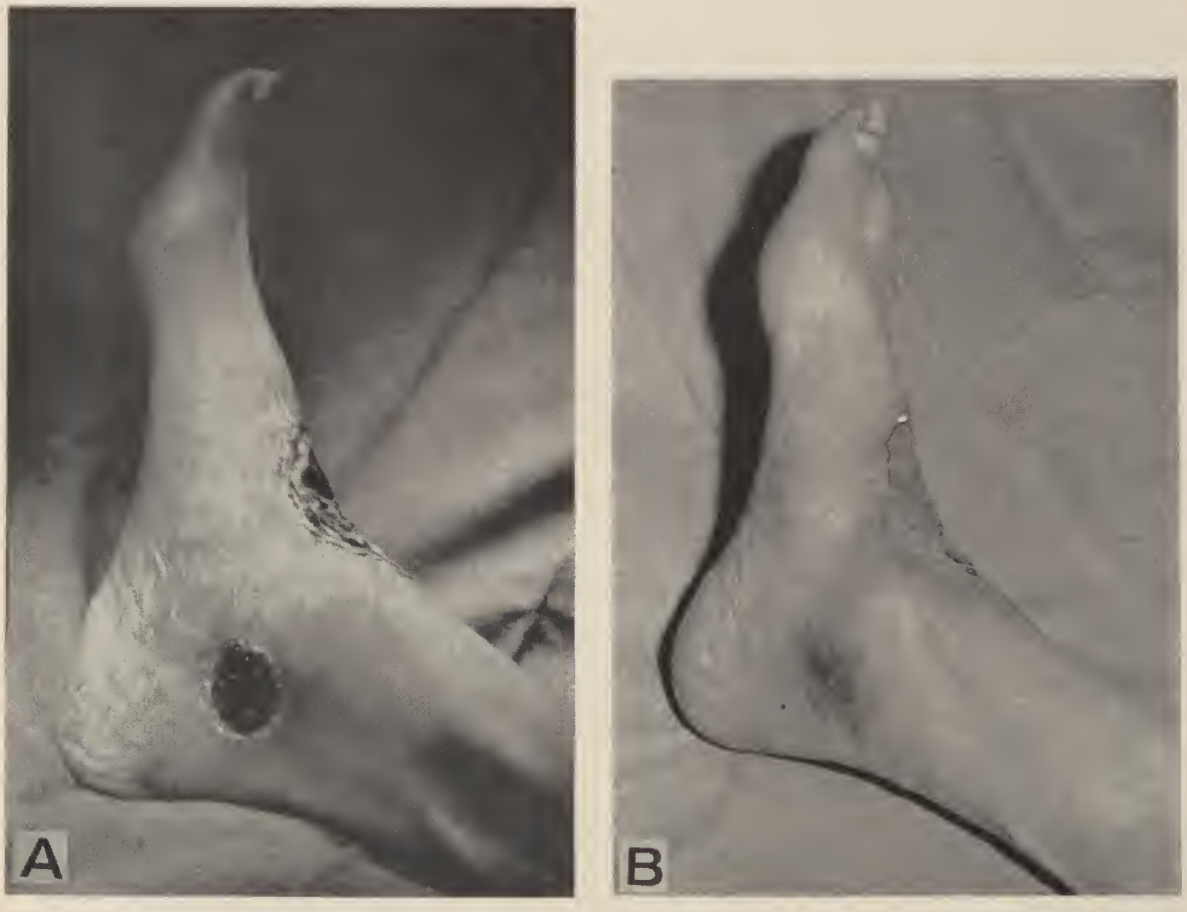


Fig 8

A. A photograph of the right foot of a man, age 64, with severe aortoiliac and femoral occlusive arteriosclerosis and ischemic necrosis of the dorsum of the foot and inner aspect of the ankle.

B. A photograph of the same foot taken five months after a first stage aortoiliac and common femoral artery endarterectomy and followed in six weeks by a second stage implantation of a 37cm saphenous vein bypass autograft with an angioplasty to the proximal end of the graft (see fig 4). The patient has returned to work with complete healing of the extremity. This is an excellent example of a good result obtained by making certain of getting an adequate inflow of blood by a proximal endarterectomy and then the utilization of a saphenous vein bypass autograft.

is present it can be corrected before closure of the incision.

A follow-up of 76 consecutive autogenous saphenous vein femoral to popliteal bypass grafts was carried out a few years ago without selection as to whether the patient had an excellent or poor outflow from the popliteal artery. Analysis of these cases demonstrated why I believe a saphenous vein autograft offers the best method of reconstructing the occluded artery in the thigh. There were seven initial failures (9%) and 69 initial successes (91%). At the end of two years of follow-up there were two more failures, leaving a success rate of 86%. Then, of extreme importance, was the fact that in 23 patients followed from two to six years there were no failures (Table 2). It would seem, therefore, that the longer a saphenous vein autograft remains patent

the price of "success"

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Table 2
FOLLOW-UP RESULTS IN 76 CONSECUTIVE AUTOGENOUS SAPHENOUS VEIN FEMOROPOPLITEAL BYPASS GRAFTS

Follow-up Period	No. Grafts	No. Successful	No. Failures	Success Rate
Initial	76	69	7	91%
Early (6 mos–2 yrs)	69	65	4	86%
Late (2 yrs–6 yrs)	23	23	0	86%

the more chance it has of staying open indefinitely. This is not true of the other reconstructive procedures of femoral and popliteal arteries, such as bypass arterial homografts, thromboendarterectomy of the femoral and popliteal arteries, or the insertion of bypass synthetic grafts of nylon, teflon, or dacron.

Finally, to demonstrate what can be accomplished today that previously would have necessitated an amputation, a man 60 years old was brought in with necrotic ischemic lesions on the dorsum of his foot and behind his internal malleolus (fig 8a). Examination of his limb revealed no pulses except for very faint femoral pulses in the groins. This patient therefore had an endarterectomy of his abdominal aorta, iliac, and common femoral arteries to insure a good inflow from above. Then a saphenous vein bypass autograft from the endarterectomized common femoral artery down to his popliteal artery was inserted because a femoral arteriogram revealed a segmental occlusion of the superficial femoral artery with a patent distal popliteal and outflow arteries. The black eschars of his lesions cleared up. A skin graft was necessary on the dorsum of his foot, but amputation was avoided and the patient has returned to his occupation (fig 8b). The result has been succinctly described by one of my patients, a poet, who also had reconstructive surgery done on his legs. He wrote, "In March how black the bough, Doubter, behold it now."

This patient is one of many examples in the past 11 years in whom an extremity has been saved by reconstructive surgery on the femoral artery using saphenous vein autografts. It is necessary to keep in mind the 10 requirements for a successful arterial reconstruction in order to get the best results and to remember that most failures are the result of technical errors.

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Erythromycin—*Erythromycin, Ilotycin*
Meglumine diatrizoate—*Cardiografin, Gastrografin, Renografin*

LOOK AT THE RISK IN TERMS OF GAIN

It would appear then that the future family physician will discuss the hazards of medical therapy in advance with the patient and family much as the surgeon does at present. As medical complications become less covert, the practitioner, like the investor, the politician, or the surgeon, will have to weigh risk in terms of gain. John F. Stapleton, MD, in Archives of Environmental Health, (11:140), August 1965.

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

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Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

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IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

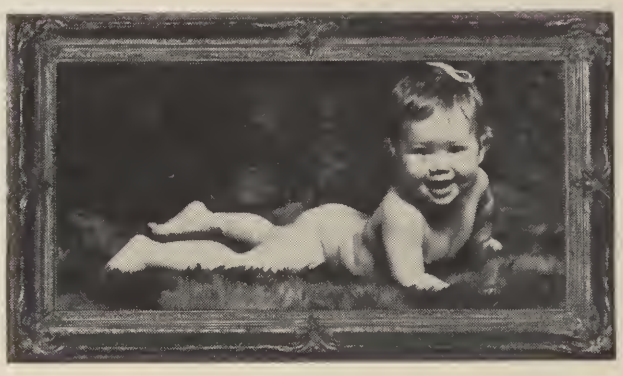
Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

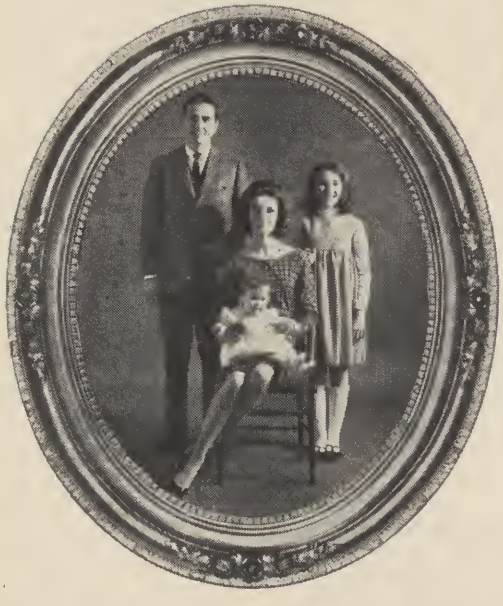
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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GREATER BALTIMORE MEDICAL CENTER DEDICATED

The Greater Baltimore Medical Center was publicly opened with dedication ceremonies on Saturday, October 2, at which time General Dwight D. Eisenhower and his brother, Dr. Milton S. Eisenhower, were featured guests. The institution merged the Hospital for Women of Maryland and Presbyterian Eye, Ear, and Throat Charity Hospital.

Now open on a 60 acre site, the all-new Greater Baltimore Medical Center will provide ultimately a 600 bed hospital built around a core consisting of a spiral ramp for "locomotive" delivery of supplies.

Related to the delivery system is another unusual aspect of the project. Built into a hillside, the hospital is already being called the "upside-down hospital" and the "gravity fed hospital," because delivery docks and basic supply centers are located on the top floor. This fifth floor contains such departments as dietary, stores, central supply, and pharmacy.

The horizontal plan of the hospital presents a swastika effect with patient wings extending from the central delivery core.

A tractor will travel up and down the spiral ramp, hauling a variety of supply carts on what has been carefully calculated as 18 hours a day of continuous activity. As programmed, surgical linen delivery will begin at 6 AM and an in-and-out linen delivery will take place at 8:30 PM. Late every evening floor cleaning is among the miscellaneous duties of the system. The new center plans to use one electric-powered tug,

continued on page 52

These firms are among those who worked on the Greater Baltimore Medical Center . . .

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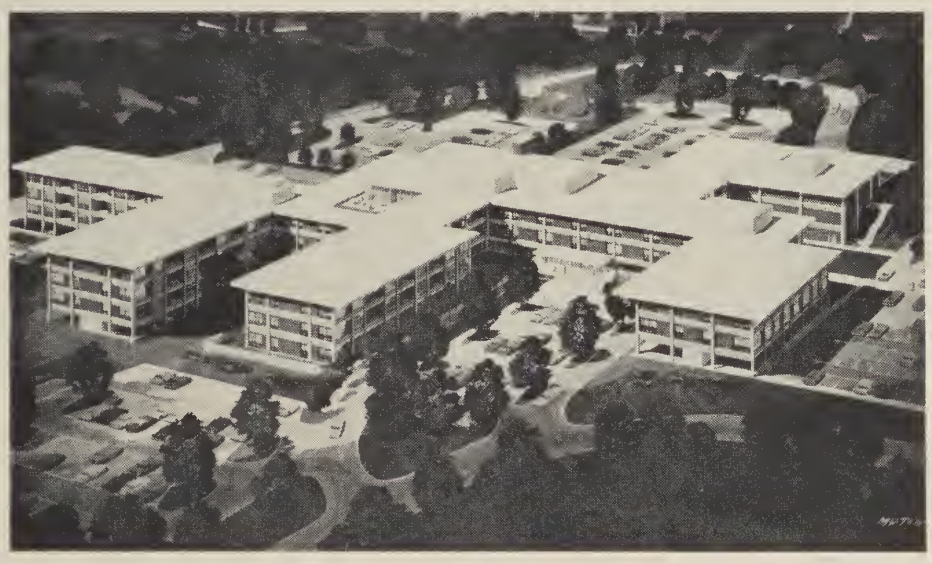
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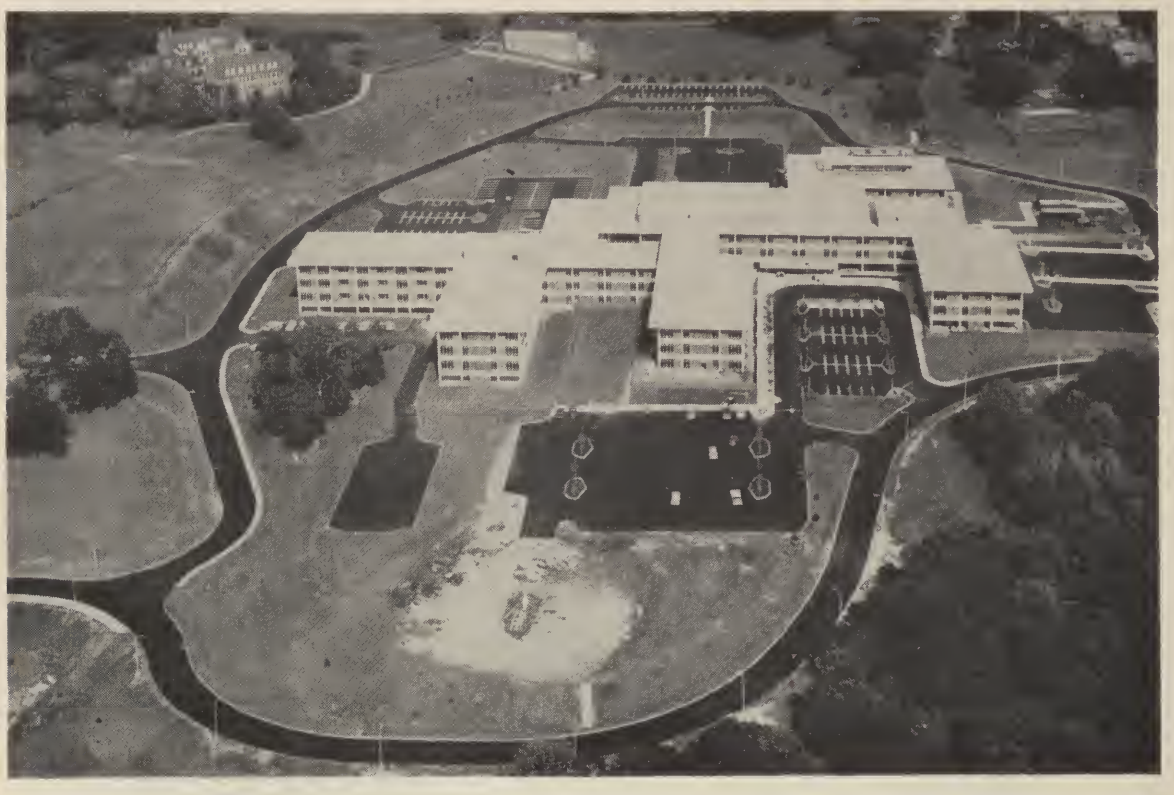
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The Greater Baltimore Medical Center stands as a tribute to those men and women who brought together two traditions of concern for human welfare in a single vision of how best to implement that concern in a rapidly changing metropolitan situation. Consolidated salutes this remarkable medical facility and all those who took the first decision to go forward. We are proud to have had a hand in turning their vision into a public achievement.

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and four drivers are scheduled to staff the conveyance. The ramp has three exits at each level, allowing the cart to travel varying lengths down service corridors to planned turn-around points. From these terminals, carts can be detached for manual delivery into nursing units and other smaller areas where needed.

Supplementing the locomotive delivery is another unusual supply system: an overhead conveyor with baskets suspended from the link chain to carry smaller items (eg, paper records, laboratory specimens) throughout the wings of the hospital.

A central dispatch center controls both the basket deliveries and the scheduling of the carts. In the detailed planning, studies anticipate, for example, that six runs a day with food carts will require 222 minutes, linen delivery will require 158 minutes, and separate runs with contaminated supplies and with trash will require 180 minutes each.

It is believed that much of the discipline of the hospital can be influenced by the scheduling of the trains. A particular advantage of the ramp system will be freeing elevators and stairways for the use of patients, visitors, and staff.

Because of the hillside site, ground-level entrances will be possible on most floors. Parking areas will circle the hospital. The service drive directly approaches the loading docks from the top of the hill against which the hospital is built.

Immediate services call for 400 beds and 84 bassinets with early expansion to 600 beds. In the first stage, complete outpatient and emergency facilities, including new audiometric clinics in the eye, ear, and throat wing, will be provided. Later expansion calls for geriatric service, residential space for staff and visitors, and research and teaching units.

The entire hospital is planned on the progressive patient care concept with a complete range of inpatient care from intensive care to self-care areas.

The total project will provide 311,000 square feet of space at an estimated cost of $13 million.

With the merger and move to the Towson area, the former Women's Hospital has been sold to a private concern for use as a nursing home. The Presbyterian Eye, Ear, and Throat Hospital will continue to use its old building as a general clinic administered by the GBMC.

COMPONENT MEDICAL SOCIETIES



BALTIMORE CITY

On September 7 the Baltimore City Medical Society delegates to the Medical and Chirurgical Faculty of Maryland met with the Board of Directors to discuss resolutions which were to be presented at the Semiannual meeting of the House of Delegates in Ocean City.

The most controversial resolution dealt with non-participation on the part of the faculty and its members in HR 6675 (Medicare). The resolution stated in part that, while continuing to render medical care as always to our patients, we should refuse to participate with the program as outlined in HR 6675, specifically noting the right to refuse to sign any papers relative to HR 6675, to refuse to execute any certificate as described in this legislation, and to refuse to accept any fees from any agency of the United States government under the provisions of this act.

The Committee on Public Medical Education is negotiating with WJZ-TV to have physicians appear for a five-minute interview once a week on a program called "Mid-day," which can be seen daily from 12 to 12:30 PM. The following physicians have agreed to participate: **Erica Moszkowski, MD, Cyrus Blanchard, MD, Erney Maher, MD, John Imboden, MD, B. Richard Shackelford, MD,** and **Harry Klinefelter, MD**

Joseph D. B. King, MD

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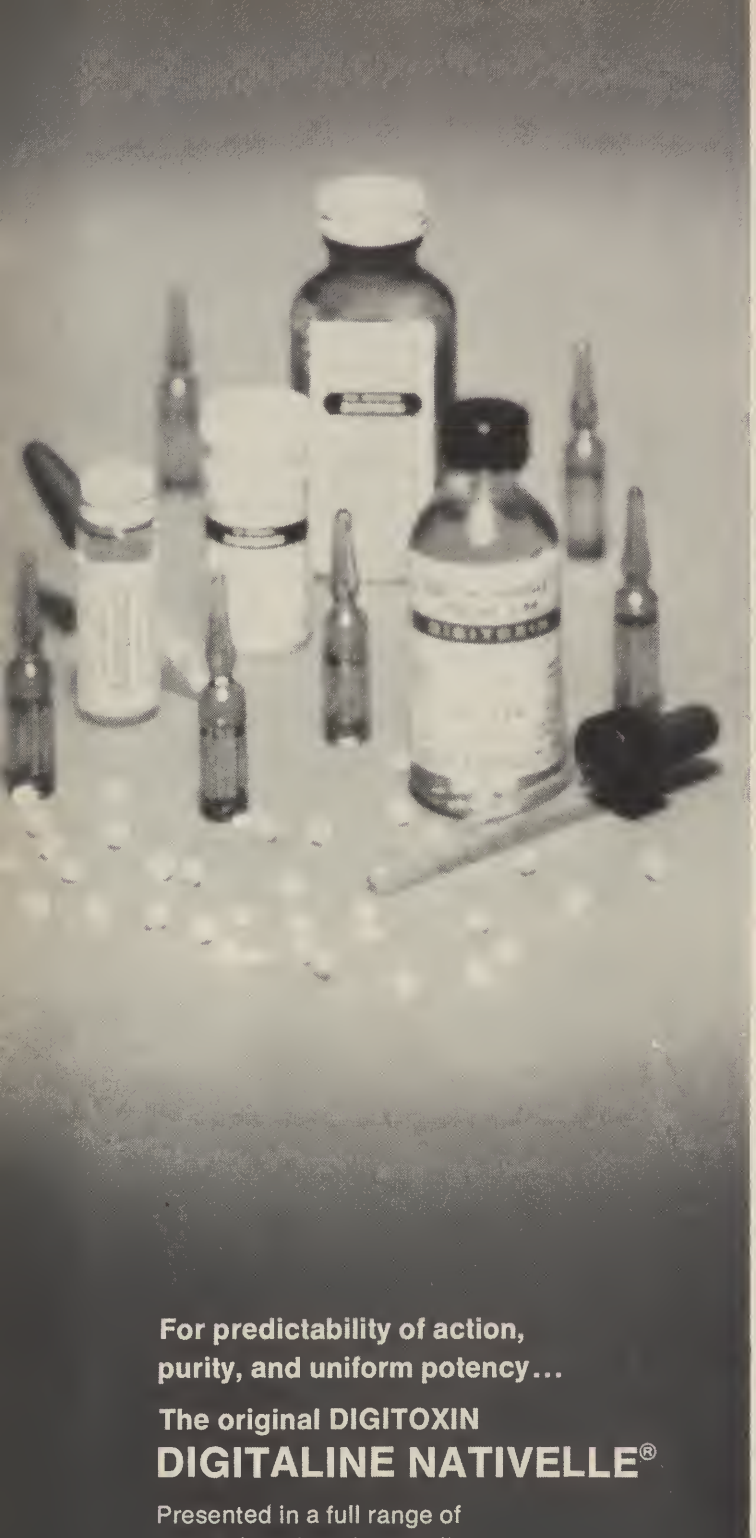
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Administration of Blood and Other Intravenous Fluids in the Baltimore Area

W. BRADLEY KING, JR., MD

EARLY THIS SUMMER a questionnaire was sent to the pathologists directing the laboratories of 21 general hospitals in the Baltimore area in an attempt to define the division of responsibility as far as the administration of blood, blood products, and other intravenous infusions was concerned. The questionnaire contained five questions to ascertain which hospital employees were empowered to administer blood, blood products, and other intravenous fluids.

The questions were:

1. When a blood bank technologist, technician, or extern primarily employed by the laboratory is not on duty in the blood bank actually to release blood from the blood bank, who may pick up previously crossmatched blood from the blood bank refrigerator(s)?
2. Who may start blood in your hospital?
3. Who may start non-whole blood products (plasma, Plasmanate, serum albumin, etc.)?
4. Who may start IV infusions (not including any blood products)?
5. Do you differentiate between who may start whole blood or other blood products primarily and who may start whole blood or other blood products as a "piggy-back" transfusion (that is, inserting the needle into already existing intravenous infusion tubing)?

Although not all conceivable employee categories were considered, the trend of responsibility seems to be clearly indicated. The actual choices offered the pathologists at the hospitals were: house officer, fluid team registered nurse; fluid team non-RN member; others).

The table shows the replies of the 17 hospitals who returned the questionnaire:

It is obvious that the Baltimore area hospitals regard blood transfusion as such a serious procedure that only limited groups of specially trained or highly responsible personnel should be permitted to administer it. Surprisingly, however, there was an equally strong feeling about the infusion of other intravenous fluids, for which explanation seems less obvious.

It is difficult to know whether responsibility for administration of blood and intravenous fluids should be expanded beyond the physician and fluid team categories or whether to restrict further the administration of blood and its products and other IV fluids to only these two groups. If one abides by the axiom that to be safe legally in the event of an untoward result, one should not do anything which is not the general practice in the community, than it would seem wise to restrict the administration of blood and its products to these two specially trained and responsible groups of personnel.

Some hospitals do not have intensive care units; in other hospitals these units are staffed with as much difficulty as the rest of the hospital, due to the general shortage of nurses. It would seem reasonable to believe that nurses capable of being charged with the running of intensive care units

Categories of Hospital Personnel*	Questions 1†	2	3	4	5
House officer (and attending physician)	10	17	16	16	17
Fluid team—RN	5	9	10	13	11
Fluid team—non-RN	—	—	—	1	1
RN-general or private	2	—	—	2	3
RN-supervisor	7	1	2	2	3
RN-ICU	2	1	2	2	3
RN-anesthetist	2	1	1	1	2
Licensed practical nurse (LPN)	2	—	—	—	2
Nurse's aide	2	—	—	—	—

should be able to do venipunctures with almost as much alacrity as members of the fluid team. Such ICU nurses should therefore be expected to do same, both for the purpose of drawing blood specimens and of starting intravenous fluids, including blood. It would seem also that fluid team nurses should be permitted to start all IV fluids.

Two conclusions, at least, may be reached from the apparently desirable limitation of responsibility for the administration of blood in particular and other fluids in general. They are as follows: First, because of the increasing complexity of blood antigens and antibodies (in part as a result of prior transfusions) there is an inherent danger in administering a blood transfusion to any patient. Thus, too, progressively greater difficulty might be expected in precluding any sort of reaction to a blood transfusion, as well as the serious medical or legal consequences, or both, of a mismatched transfusion. Second, and perhaps even more important because it indicates the direction of medical care and the effect upon it of legal actions, is the apparent *fear* of allowing *any*body to administer blood who is not a physician or who is not charged with the specific responsibility of administering fluids all the time. It would seem reasonable that if physicians and fluid team nurses (a non-RN fluid team member should definitely be excluded from administering IV fluids of any kind!) can learn to practice the usual safeguards necessary to begin safely the intravenous infusion of blood, then anybody can also be taught these precautions. Then, to indicate categorically that only a fluid team nurse or only the house officers should be allowed this responsibility seems to be making a mountain out of a molehill. On the other hand, because of the dangers involved and because unusual care *is* necessary, it should not be given to just anybody to do; but, on the other hand, this responsibility should not be so restricted that only fewer and fewer people are given it.

As an example of the significance of both of these conclusions, it is apparent (from the replies received) that the beginning of a second unit of blood is regarded with as much temerity as the beginning of the first. Yet the actual technique of doing a venipuncture—which may be the most *difficult* part of giving a transfusion—has in such instances been eliminated. Here, then, should be one area where any other nurse who can keep her mind on what she is doing should be allowed the responsibility of starting a second or third unit of blood when all she has to do is plug it into the tubing already existing. However, we must never forget that this second unit carries with it the same inherent dangers as the first unit, and its administration should be made with just as much caution. On the other hand, if the feeling is that we physicians are afraid, as a result of many litigations, many of which are based on the most specious foundations, then the administration of blood, either primarily (into the vein) or secondarily (into the tubing), should be restricted to even fewer people. In the latter case, the physicians and fluid team nurses will have to assume an even greater load of responsibility and work.

With some degree of stability in the personnel turnover in any given hospital, it would be hoped that something in the way of a compromise might be found.

*No specific question was asked about medical students, because most hospitals do not have medical students as part of their personnel. When present, they are under the close supervision of the house officer and would probably be considered in the same category.

†Two hospitals indicated that someone was *on duty* in the blood bank 24 hours a day; and no one else could remove blood from the bank.

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The Heart Page

Ralph Weber, MD—*Editor*

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MITRAL VALVE REPLACEMENT

SAFUH ATTAR, MD

MOST PATIENTS presenting with mitral valve disease at the University of Maryland Hospital are studied by right and left heart catheterization and cineangiocardiography. Patients with pure mitral stenosis are operated on by a closed mitral commissurotomy, using either the finger or the transventricular dilator depending on the yielding of the commissures to the finger dilatation and the adequacy of the mitral opening. Open heart surgery using cardiopulmonary bypass is used in patients with mitral stenosis having a previous history of emboli or angiocardiographic findings of left atrial thrombus. When an atrial thrombus is encountered during a closed mitral valvulotomy, the operation is converted immediately to an open procedure to prevent the escape of fragments of atrial clots into the systemic circulation.

Total replacement of the mitral valve is undertaken when there is: 1) restenosis of the valve after an adequate previous valvulotomy with fixation of the cusps, matting and shortening of the chordae tendinae; 2) severe calcification; 3) mitral insufficiency; 4) combined stenosis and insufficiency of significant degree.

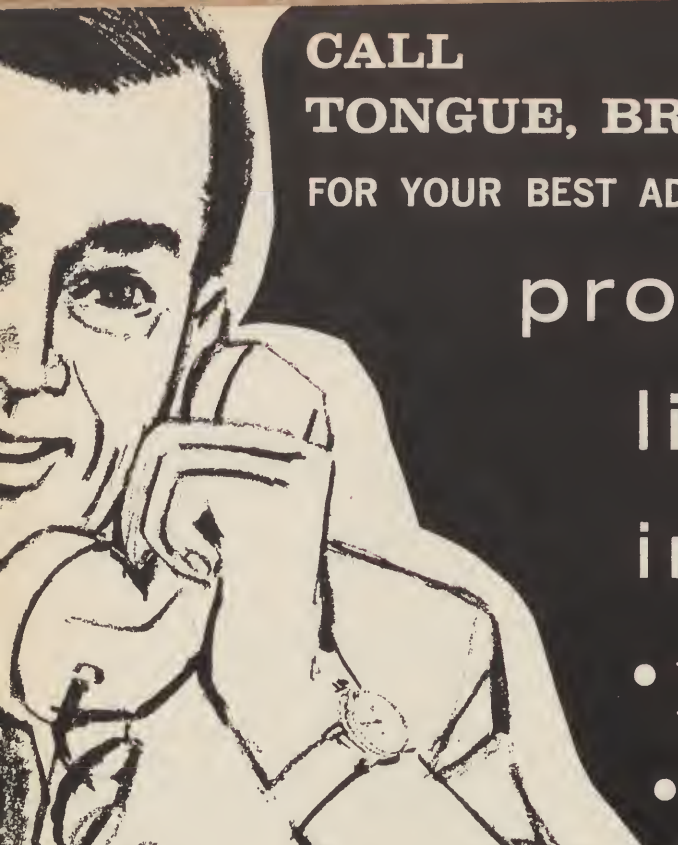
Despite the increasing experience and decreasing mortality in total valve replacement, the complication rate remains high, and we make every effort to preserve the original valve if possible. However, our experience and that of others has demonstrated that plastic reconstructive procedures on the mitral valve, such as decalcification, annuloplasty, have little to offer, since the benefits are of short term and the recurrence rate is high.

From the Department of Surgery, Division of Thoracic and Cardiovascular Surgery, University of Maryland School of Medicine and Hospital.

During the past three years, we have inserted 59 mitral valve protheses using the Starr-Edwards ball valve. Fifty-three were in patients with mitral stenosis and insufficiency or both, and six were in patients having double valve replacement in the aortic and mitral areas. Most were classified as class III or IV, according to the American Heart Association classification, and 20% had undergone previous valvular surgery. In the mitral valve group (excluding the double valve replacement), the immediate mortality (within 30 days of sur-



Chest x-ray showing Starr-Edwards valve prosthesis in the mitral area. The resected mitral valve was markedly calcified and stenotic.



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gery) was 18%. Postoperative complications consisted of psychosis, wound infection, serum hepatitis, cerebral embolic phenomena, peripheral vascular occlusion, and suspected partial valve detachment. There were five delayed deaths due to valve detachment in two, valve clotting in one, serum hepatitis in one, and renal failure in one.

Most of our patients with mitral valve replacement are placed on anticoagulants five days after valve replacement. Their prothrombin activity is checked regularly thereafter. The results in the surviving patients have been gratifying, since most have been rehabilitated to an active and useful life. However, the ideal prosthesis to replace the mitral valve is not yet available. The double-cage Smeloff-Cutter valve is a modification of the Starr valve. This affords a larger mitral orifice, thus diminishing the residual stenosis inherent to the Starr valve and, hopefully, decreasing the incidence of clotting and emboli.

The latter problem remains the most serious drawback to all available prosthetic valves. Efforts to minimize this problem include the removal of all the calcium imbedded in the mitral ring, early electrical conversion of atrial fibrillation, and the use of anti-coagulants. The incorporation of heparin in the prosthesis might offer an additional safety against the formation of thrombi.

MARYLAND RADIOLOGICAL SOCIETY
ORGANIZED 1953

President—James A. Lyon, Jr., MD
Editor—Donald A. Wolfel, MD

Carcinoma of the Cervix in Pregnancy and the Puerperium

THE INCIDENCE OF carcinoma of the cervix during pregnancy is low and is estimated at .05% of pregnant women. It represents 1.5% of all cases of carcinoma of the cervix, and the puerperium cases add an additional 1.5%. The reasons for these low incidences are readily evident, as the child bearing age is below the maximum cancer age of 50-60 years. Also, many patients with advanced carcinoma are sterile and, in actual experience, most cases found are classified in stage I or II of the disease.

There have been many thoughts about the interaction of pregnancy with carcinoma of the cervix. Practically every point of view has been taken on their possible relationship. Table 1, from Palmer's review of the problem, depicts the dichotomy of past opinions.

Two basic considerations form the point of departure in our approach to the problem. First, should the patient deliver through the pelvis, there is a much greater risk of tumor spread. The combination of mechanical pressure on the tumor with the widely dilated vasculature and exposed tissues will make lymphatic and hematogenous spread more probable. The possibility of hemorrhage and infection is also increased, especially in the presence of a necrotic tumor which is in all likelihood already infected. The same problems attend any surgical or traumatic intervention of the pregnancy.

The second consideration is that the action of irradiation is deleterious to the fetus. A total body dose of four hundred rads is almost always lethal and usually produces abortion within six weeks. Sublethal doses may produce many malforma-

MICHAEL S. TENNER, MD
Department of Radiology
University Hospital

Table 1
MUTUAL EFFECTS OF PREGNANCY AND CARCINOMA OF THE CERVIX

Carcinoma of the Cervix Prevents Pregnancy	
	Mauriceau
	Mankin
Pregnancy Accelerates Carcinoma of the Cervix	
	Danforth
	Wertheim
	Hunter
	Ewing
	Kobak
	Maino
	Montgomery
	Mussey
	Simpson
	Ward
	Zimmerman
	Senator
High Estrogen Predisposes to Carcinoma of the Cervix	
	Ayre
Pregnancy Prevents Carcinoma of the Cervix	
	Baer
	Danforth
	Ward
Pregnancy Decelerates Carcinoma of the Cervix	
	Emge
	Mayer
	Peller
	Stockl
	Wolff
Youth Accelerates Carcinoma of the Cervix	
	Emge
	Maino
	Marcus
High Estrogen Controls Carcinoma of the Cervix	
	Nieburgs

From Waldrop and Palmer: *Amer J Obstet Gynec* 86: 202-212, 1963.

Table 2
TWENTY-SIX PATIENTS — 1956-1962
Two- to Five-Year Followup

	1st Trimester	2nd Trimester	3rd Trimester	Puerperium	Total
Stage I	8 (7 alive)	7 (5 alive)	3 (3 alive)	5 (4 alive)	23 (19 alive)
Stage II	2 (2 alive)	.....	1 (1 alive)	.....	3 (3 alive)
Total	10 (9 alive)	7 (5 alive)	4 (4 alive)	5 (4 alive)	26 (22 alive) 85%

tions, the type of abnormality being related to the time of gestation at which the irradiation was given and to the protraction of the irradiation. The tolerance of irradiation increases with fetal age, and by term the tolerance is similar to that of an adult. In fact, there are cases of localized irradiation to the fetal head from vaginal radium in which the only abnormality produced was epilation of the fetal scalp.

These considerations form the basic principles of treatment policy which can be summarized as follows:

1. The state of pregnancy will not alter the behavior of carcinoma of the cervix either from the standpoint of its local or distant spread or its responsiveness to irradiation.
2. Any trauma (surgical interference or pelvic delivery) should be avoided if at all possible before a substantial amount of irradiation has been delivered.
3. The longest period possible between the beginning of irradiation and delivery should be obtained. This is true whether delivery is contemplated by vaginal route or by hysterotomy. In general this means using vaginal radium first. This is followed by external irradiation using high total pelvis doses and ending with intrauterine radium a few days after the uterus is emptied. The main merit of this approach is that it will greatly reduce the activity of the tumor cells or frankly sterilize them before the trauma of delivery occurs. In most cases enough time is obtained by this approach, as delivery usually takes place at about the third or fourth week after the beginning of therapy.
4. External irradiation should always be given in sufficient amounts to produce the death of the fetus. If the dosage has not proved lethal, the consequent malformations may ultimately prove to be so, and this should be avoided. The exception to this rule is the fetus at the end of the last trimester which has received only localized low irradiation from vaginal radium.

The details of treatment policy at University Hospital are given below. External irradiation is given by cobalt teletherapy. The Fletcher system of radium application is used.

In stage I and early stage II (only small invasion of fornices):

1. Vaginal radium for 96 hours.
2. Total pelvis irradiation to deliver 2,000 rads to the midline.
3. Abortion usually occurs spontaneously at this time.
4. Two days after abortion an intrauterine tandem three to four inches in length loaded with 15-10-10 or 10-10-10-10 mg of radium is used for 96 hours. Vaginal packing is omitted to ensure drainage.
5. External parametrial irradiation is employed to bring the tumor dose to the pelvic walls to 4,000 rads.

In the remainder of stage II and all of stage III and IV:

1. Total pelvis irradiation to a tumor dose of 4,000 rads.
2. Vaginal radium for 72 hours.
3. Abortion usually takes place at this time.
4. Intrauterine tandem for 72 hours.
5. Parametrium brought to a tumor dose of 5,000 or 5,500 rads.

The exceptions to this therapy program are as follows:

1. In the last part of the last trimester it may be advisable for social and emotional reasons to obtain a viable fetus. If this is the case, no irradiation is given and the development of the fetus to full viability is awaited, at

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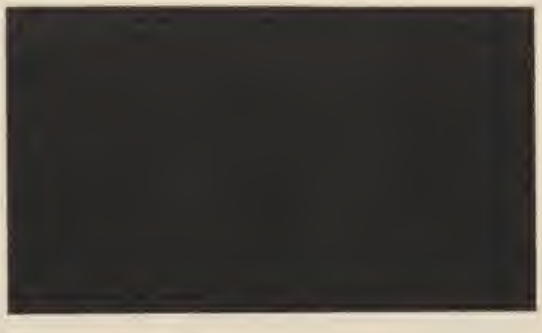
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which time the fetus is delivered by classical cesarean section. Irradiation is then given in amounts as previously outlined.

2. The puerperium cases are treated in the routine manner of any carcinoma of the cervix without pregnancy except that higher tumor doses are given to the total pelvis and the parametria. All cases should have 4,000 rads total pelvis, one radium application for 72 hours, and additional parametrial irradiation to 4,500-5,500 rads to the pelvic walls, depending upon the extension of the disease.

Our experience at University Hospital is summarized in Table 2. Four patients died, three from pelvic wall recurrence and one from distant metastases. These survival rates compare favorably with those in carcinoma of the cervix without pregnancy.

In summary, pregnancy has little or no influence in the course of carcinoma of the cervix or its responsiveness to irradiation providing sufficiently high doses are administered to the total pelvis and parametria. Interference with pregnancy by surgical or traumatic means should be avoided. If the fetus has received total body irradiation, its sacrifice should become an acceptable part of treatment.



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REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

THE ARTHRITIS FOUNDATION, MARYLAND CHAPTER

DOUGLAS CARROLL, MD

OVER THE LAST FEW MONTHS in Rehabilitation Notes, an attempt has been made to present some of the important practical aspects of the rehabilitation of patients with rheumatoid arthritis. A resource which may be of particular help is the Maryland Chapter of the Arthritis Foundation, which carries on a program of services and education for patients and physicians as well as an active research program.

Among the services available to practicing physicians is the Evaluation Clinic. This clinic meets weekly. It is designed to help physicians who have patients with arthritis problems. A doctor (or the patient with his physician's permission) may obtain an appointment to the clinic by phoning the Maryland Chapter office at 889-9032.

This is purely a consultative service. A convenient appointment is made, and the patient is expected to bring with him all the available x-ray and medical records plus the name and address of his referring physician. The clinic is limited to a small number of patients each time so that minimal time is lost in waiting.

At the clinic the patient is examined by a rheumatologist, who first reviews all the accumulated medical data. The consultant then outlines a program of treatment on a written report form, which is returned to the referring physician for his consideration. If laboratory tests and x-ray films are necessary for proper diagnosis and evaluation, these will be arranged and done at the chapter's expense.

In a limited number of cases, consultation with an orthopedic surgeon is advisable. When indicated, the patient will be invited to return to the next clinic for which an orthopedic surgeon is scheduled. The orthopedic surgeon's report is also sent to the referring physician.

Where community agencies, such as the Instructive Visiting Nurses, Physical Therapists, or other special services are needed, the consulting physician will indicate how these may be obtained. The consultant's reports are then returned to the referring physician, who may use this information at his own discretion. The report will not be discussed with the patient other than in general terms by the clinic physician.

There is no charge made to the patient for the use of this Evaluation Clinic of the Arthritis Foundation. The chapter is a member of the Community Chest, operating with funds raised in the annual United Appeal.

Other services may be performed for patients or for the physician on specific request to the Arthritis Foundation. When the Foundation itself is unable to perform a requested service, it is often possible to arrange with the proper agency for assistance.

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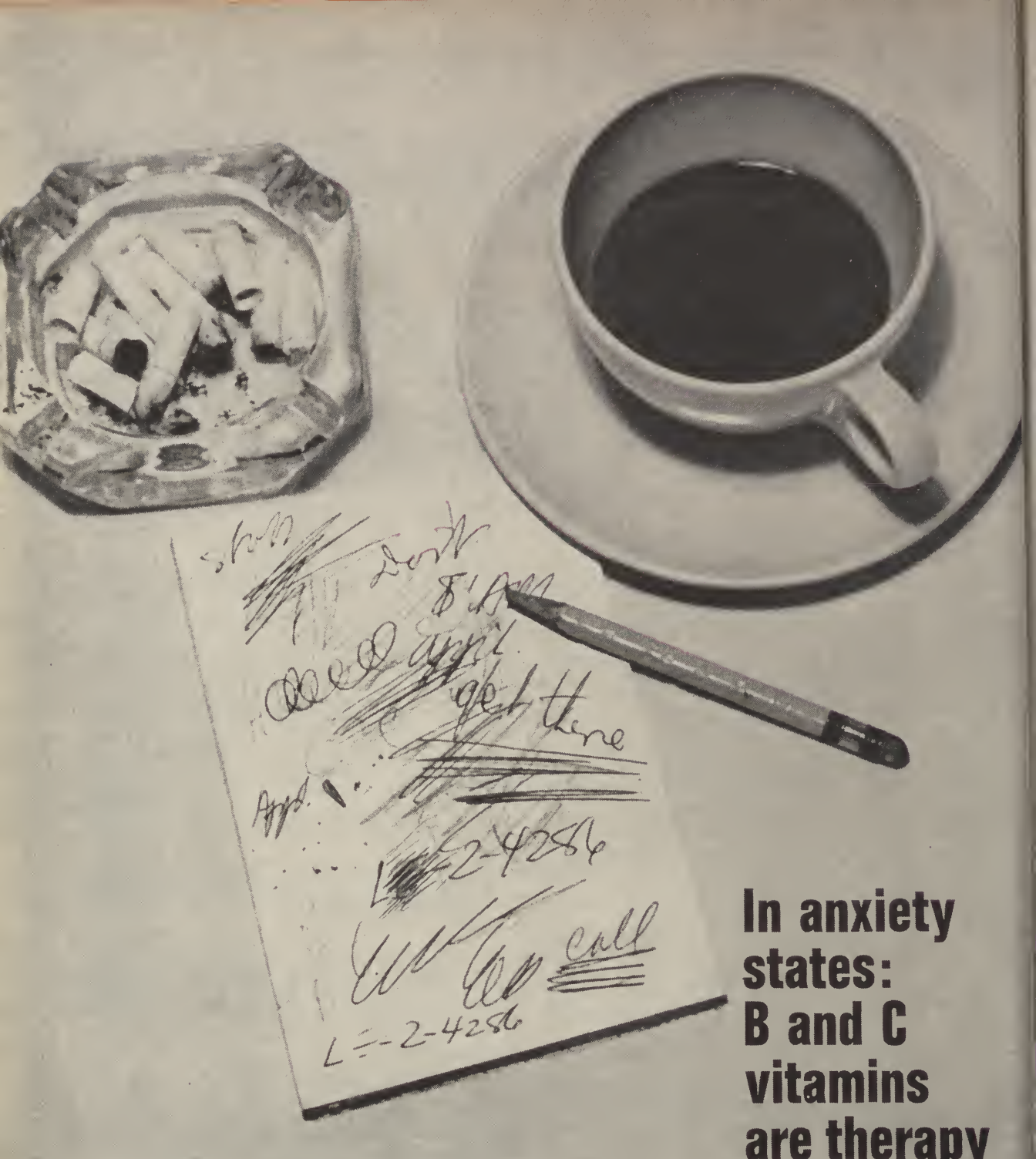


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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Male Pride and the Alcoholic Wife

MARY F. BACON
Director, Melwood Farm

MALE PRIDE is a very powerful emotion and can be a very destructive one if the male happens to have an alcoholic wife. One reason it was long thought that male alcoholics outnumbered females by five to one was because the husband's pride wouldn't permit the wife's condition to become known outside the family. Not too many years ago female alcoholics were treated like lepers and relegated to the attic with a daily ration of whiskey while a housekeeper took over down below until death finally released the husband from his "burden."

Today many a husband of an alcoholic still says, "Why should this happen to *me?*" He is bitterly resentful that the woman he has selected for a mate should thus "let him down." His male pride has taken a terrific beating—his household has fallen apart, he is afraid to bring his friends home, he has been embarrassed in public—perhaps openly reviled and mistreated.

When the situation becomes unbearable—*for him*—he may grit his teeth, take his wife to a treatment center, shove her inside, and say to the staff, "Here she is—cure her!" The patient recovers—temporarily, but the doctor knows she hasn't a prayer of permanent recovery until the husband's attitude changes or she can get up the courage to leave him.

Or he may attempt to treat her himself in private. This is often done by physicians whose wives are alcoholics. Unfortunately, only a small percentage of the practicing physicians in the United States today understand the illness of alcoholism or how to treat it. Some of them give their wives tranquilizers and/or barbiturates and succeed only in adding another addiction to the original addiction to alcohol.

Injured male pride also may take the form of an angry, domineering attempt to manage every aspect of the alcoholic wife's life. This usually leads to renewal of drinking and an early death if some third party doesn't step in.

When his pride is too deeply hurt, the husband of an alcoholic may reject her completely by withdrawing into himself and having no communication with her, or even by packing his bag and leaving. Another form of rejection sometimes used is to throw the wife out of the house, usually without funds. Obviously, if she is to live, she will have to find help elsewhere.

The fortunate wife today is the one whose husband asks not, "Why should this happen to *me?*" but, "Why should this happen to *her?*" and then proceeds to *find out why.* He finds that she is the

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victim of an incurable disease which, if not arrested, can lead to death or insanity. He learns to accept the fact that his wife is a sick woman—not a demon sent to torment him—that she has a treatable illness and that, with help, she can in time recover. He learns that her illness is threefold: physical, mental, and emotional. He seeks help and guidance for himself while carefully steering her in the direction of treatment. He consults competent doctors, clergymen, and those most fitted by experience to help him, the members of the Alanon Family Group, an auxiliary of Alcoholics Anonymous composed of the wives and husbands of alcoholics.

He learns that there is much he must do to *change himself* if he is to return to a normal life and help her to recover. Old attitudes, mental and emotional, must be scrapped and replaced with new, constructive, positive ones.

The old male pride caused him to put innumerable roadblocks in the way of his wife's recovery, but a change of attitudes, lots of patience, and some real effort on his part will eventually produce a genuine feeling of pride in her recovery—and his own.



Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 5: Postpartum Infection

The patient was a 40-year-old primigravida, whose estimated date of confinement was April 5. Her prenatal course is reported as completely normal, but there are no records of pelvic measurements. Her past history was essentially uneventful except for a myomectomy performed in another hospital in 1956.

On May 2, approximately four weeks past term, she was admitted to the hospital at 4:30 PM, having had spontaneous premature rupture of the membranes. She was not in labor, and the admission physical examination was essentially negative, with the blood pressure 130/80, fetal heart 132 per minute and strong. At 10:30 PM the patient was having mild contractions every 20-25 minutes and was thought to be 3-4 cm dilated. At 4 AM she was seen in consultation. Because of doubt about the presentation, a flat plate of the abdomen was taken, which revealed a double footling presentation. Antibiotics were given, and she continued in labor, with contractions coming every five minutes. On May 4, approximately 48 hours after admission, it was felt that the patient was fully dilated and she was taken to the delivery room. Examination at this time revealed only a pinpoint dilatation of the cervix, with a greatly thinned lower uterine segment through which the presenting parts could be felt. A decision was reached at this time to carry out cesarean section.

At operation, multiple adhesions to the body of the uterus were encountered, as well as a number of fibroids. A living male infant in good condition was extracted. Supracervical hysterectomy was performed, and the patient left the operating room in good condition. Her postoperative course was essentially uneventful until May 8, at which time there was moderate abdominal distention and drainage of some pink fluid from the upper end of the incision. The incision was explored and the fascia found to be intact. A flat plate of the abdomen showed some evidence of small bowel obstruction. She was continued on antibiotics, including chloramyphenicol, and on sodium hydrocortisone succinate (Solu-Cortef). Temperature, pulse, and respirations were normal, and the patient was expelling flatus.

On May 11 her condition began to deteriorate, and she was seen by a surgical consultant, who felt there was definite mechanical obstruction. The patient was given local anesthesia, and the abdomen was reopened. Mechanical obstruction of the bowel (site not specified) was encountered and released. After this second operation her temperature rose abruptly and blood pressure began to fall. In spite of all combative efforts, the patient died approximately 12 hours postoperatively. During her hospital stay she had received a total of 1,500 cc of whole blood, in addition to intravenous fluids and other general supportive therapy. Autopsy permission was not obtained.

COMMENTS

The committee unanimously voted this as a preventable maternal death. There were five valid reasons why cesarean section should have been undertaken much sooner: 1) the patient's age and parity, 2) history of previous myomectomy, extent undetermined, 3) breech presentation in an elderly primigravida, 4) ruptured membranes with no labor, and 5) a patient four weeks past term by dates.

The combination of these factors certainly seemed to indicate prompt cesarean section. Furthermore, there is no information about the adequacy of the pelvis, either clinically or by x-ray pelvimetry. In a patient with presumably unknown

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pelvic capacity and all of the other factors involved, immediate cesarean section at the time of admission, or even elective section, would, in the committee's opinion, have been in order. Whether the events that transpired postoperatively would certainly have been prevented had section been done sooner is, of course, open to speculation. However, the 48-hour period of presumed labor with ruptured membranes certainly added to the hazards of surgery and the chance of postoperative infection.



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Intensive Habilitation of Severely Retarded Children

BARBARA J. ALPHIN, RN, BS
Assistant Director of Nurses
Rosewood State Hospital

SEVERELY RETARDED CHILDREN have generally been considered untrainable, particularly in large institutions. Usually they receive only minimum routine institutional care.

The nursing service staff of Rosewood State Hospital have long felt that these children would be amenable to highly structured teaching programs; that they could be so trained, that they would be less of a problem to themselves and the institution; that they would be able to move into more capable groups; that they could lead happier, more profitable lives.

In November, 1962, therefore, a small pilot study was started using 15 selected profoundly retarded boys between the ages of 8-15 years. For eight months they were housed separately from the rest of the boys in their cottage, and a scheduled daily routine was geared to activating them during all their waking hours. Three psychiatric aides were assigned to this group during the day and two during the evening shift. Training was made as routine as possible. The goal was to develop each child's ability to his highest level in the following areas: self-care, emotional adjustment, social adjustment, economic usefulness, language (and related) skills, and recreational activities.

After several weeks of confusion, the children slowly settled down and during the remainder of the eight months displayed slow but continual progress. Some examples of their achievements were:

1. They all became toilet trained.
2. They could dress themselves, put on and lace their shoes, wash their face and hands, and brush their teeth properly.
3. They learned to share with one another, join in group activities, and follow simple directions.
4. They learned to carry their own trays and clear the tables after eating.

At the end of the pilot study eight of the original 15 boys were transferred to a higher level cottage, where they are functioning quite well. We believe that the pilot study definitely proved that many young severely retarded children *can* be trained when separated into small groups with sufficient staffing in a highly structured, repetitious program.

For the next year we limped along with an insufficient staff. Then at the beginning of fiscal year 1965 the quota of employees for this cottage was substantially increased. We could then afford to reopen the program to include all 78 patients in the cottage.

After careful study and grouping of patients, planning daily schedules, selecting employees, meeting with all cottage personnel, recreation aide, music therapist, and cottage physician, the new program began in August, 1964, and is functioning today.

Due to the physical facilities of the building we are limited, subdividing into only four groups. Groups A, B, and C each consists of 16 patients who are considered to have the highest potential. Group D contains the remaining 30 patients. There is a total staff of 30. Each aide assigned to a group is responsible for all phases of his patients' daily lives. He attends recreation and music therapy with them and escorts them to such on and off grounds activities as trips to the Baltimore Zoo, the circus, church, swimming, and a week of day camping. Each daily activity is considered an opportunity to teach the child to perform the activity for himself; ie, the aide does not merely dress the child (which, admittedly, would be faster) but teaches him, step-by-step, to dress himself.

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A manual containing detailed instructions for each position of habit training and many recreational activities has been provided for the aides in order to assure that the same procedures and methods are being followed by every aide. It is extremely important to assure consistency, as the severely retarded child becomes easily confused and learns only through long repetition and routine. The parents, who have shown a great deal of interest in the program, are encouraged to follow the training when the children are at home.

Our project recently received an NIH Hospital Improvements Grant which started on September 1. This provides us with 10 more psychiatric aides, one certified teacher, and one recreation therapist, as well as equipment and educational supplies.

We hope that this project will lead to improved programs for severely retarded institutionalized children in Maryland and will visibly demonstrate not only that it is humane to train these children in self care but, equally important, that monies spent in training the young will result in lower costs for care when the children become adults and are capable of caring for themselves to some degree.

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The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to Butazolidin, brand of phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Butazolidin alka

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Butazolidin, brand of phenylbutazone	100 mg.
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William J. Peeples, MD, MPH, *Commissioner*

Communicable Disease Control

VACCINES WHICH ARE SAFE, effective in producing immunity, relatively cheap, easily administered, and which usually do not produce severe systemic reactions are now available for diphtheria, polio, tetanus, whooping cough, smallpox, and measles. It is believed that when 85% or more of a population has been vaccinated against any one of these diseases, there is little danger of an outbreak. Obviously, high levels of immunity in the poulation can only be reached and maintained by a continuing program of vaccinating the backlog of unvaccinated, including unvaccinated persons moving into the community and children born in the area.

In order to give the child adequate protection against as many of these diseases as possible during the more dangerous infancy and preschool periods of life, the program of primary immunization should be started soon after the child reaches the age of two months and completed as soon as is compatible with the rules governing the administration of each type of vaccine.

RECOMMENDED SCHEDULE OF PRIMARY IMMUNIZATION

Obviously, any suggested schedule of immunization is used only as a flexible guide which may be modified to fit the child's state of health, relative risk of exposure, and, within certain limits, seasonal considerations or parental convenience.

Only well children should be vaccinated.

Oral polio vaccine, except in epidemic conditions, is best administered in the fall, winter, and spring months. No program of vaccinations for an individual need be interrupted because a dose falls due in summer.

Approximate Age	Interval Between Doses	Vaccines
2 months	Start	DPT, OPV[3]
3 months	1 month	DPT
4 months	1 month	DPT, OPV[3]
6 months	2 months	Smallpox
12 months		Measles, OPV[3]
15 months		DPT
5 years		DPT, OPV[3], Smallpox
10 years		DT, Smallpox
15 years		DT, Smallpox

NOTE: DPT —diphtheria, pertussis, and tetanus vaccine
OPV[3]—trivalent oral polio vaccine
DT —adult type diphtheria and tetanus vaccine

Smallpox vaccine must not be given at the same time as measles vaccine; otherwise there is no contraindication to giving two or more different vaccines at the same time.

DPT is not given beyond the age of six years.

When a child begins his series of vaccinations at an older age than two months, the above schedule may be shortened. The interval of one month between doses of DPT and eight weeks between doses of OPV[3] must be observed.

Children are vaccinated by the family physician or in health department clinics. The proportions done by each vary from county to county. The control of communicable diseases throughout the state is a health department responsibility. In or-

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der to take full advantage of the principal tool for control of an important group of this diseases, the health officer must know the current immunity status of his population. If this level is below accepted standards, he must take steps to correct the deficiency. He must use education and provide facilities such as vaccines and vaccination clinics. This continuing program of vaccination is the only way to reduce the morbidity of these six preventable diseases and to hold it at an irreducible minimum.

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Learn To Do Your Part In The Prevention Of Disease

Cancer Deaths Rise in 1964

TOTAL RESIDENT DEATHS for all causes in 1964 numbered 11,392 compared with 12,025 in the previous year. Leading causes of death for 1964 and 1963 are shown in Table 1.

While heart disease has shown a significant de-

Table 1

	1964	1963
Diseases of the heart	4,815	5,223
Cancer	1,901	1,861
Vascular lesions of CNS	817	869
Certain diseases of early infancy	431	422
Accidents	424	506

Table 2
Resident Deaths from Cancer by Site of Cancer—
Baltimore City 1964 and 1963

	1964			1963		
Site of Cancer	Total	Male	Female	Total	Male	Female
Total Deaths	1,901	1,082	819	1,861	1,029	832
Buccal cavity and pharynx	54	43	11	48	34	14
Esophagus	52	43	9	53	44	9
Stomach	105	63	42	121	73	48
Intestine except rectum	186	87	99	193	94	99
Rectum	77	42	35	64	38	26
Pancreas	91	54	37	107	54	53
Other and unspecified digestive organs	87	49	38	81	43	38
Larynx	24	22	2	27	26	1
Trachea, bronchus and lung	351	308	43	338	299	39
Breast	170	1	169	152	1	151
Cervix uteri	70	....	70	72	....	72
Other parts of uterus	29	....	29	34	....	34
Ovary	49	....	49	39	....	39
Prostate	101	101	....	87	87	....
Kidney	22	15	7	17	10	7
Bladder and urinary organs	60	41	19	47	26	21
Skin	25	14	11	16	10	6
Brain and other parts of nervous system	30	21	9	20	13	7
Bone	17	11	6	9	5	4
Lymphatic and hematopoietic tissues	135	75	60	142	75	67
Other and unspecified sites	166	92	74	194	97	97

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Table 3
Resident Lung Cancer Deaths by Age Group ad Sex
Baltimore City, 1964

Age Group	Number of Deaths		
	Total	Male	Female
Total	351	308	43
25-29 years	1	1	0
30-34 years	1	1	0
35-39 years	5	4	1
40-44 years	8	6	2
45-49 years	16	13	3
50-54 years	31	24	7
55-59 years	53	48	5
60-64 years	75	70	5
65-69 years	63	57	6
70-74 years	50	43	7
75-79 years	32	30	2
80-84 years	14	11	3
85 and over	2	0	2

crease—408 fewer deaths in 1964 compared with 1963—cancer took 40 more lives in 1964 than in 1963. Deaths from cancer by site and by age groups are shown in Tables 2 and 3. The leading cause of cancer death is cancer of the trachea, bronchus, and lung.

Physicians can help in the fight against cancer by aiding in the current educational campaign to prevent lung cancer being conducted by the Maryland Committee on Smoking and Health and the Baltimore Interagency Conference on Smoking and Health.

In addition to general education of the public, the dangers of smoking will be emphasized to elementary school children and in junior and senior high schools through revisions in school curricula. Physicians can reemphasize the dangers to parents and children.

With reference to the early detection of cancer, the problem is basically one of getting the patient to the doctor, and this will come as the public becomes increasingly aware of cancer's seven danger signals and are motivated to see the physician as symptoms occur.

Robert E. Farber, MD
Commissioner of Health



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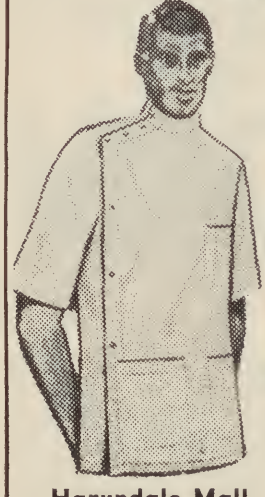
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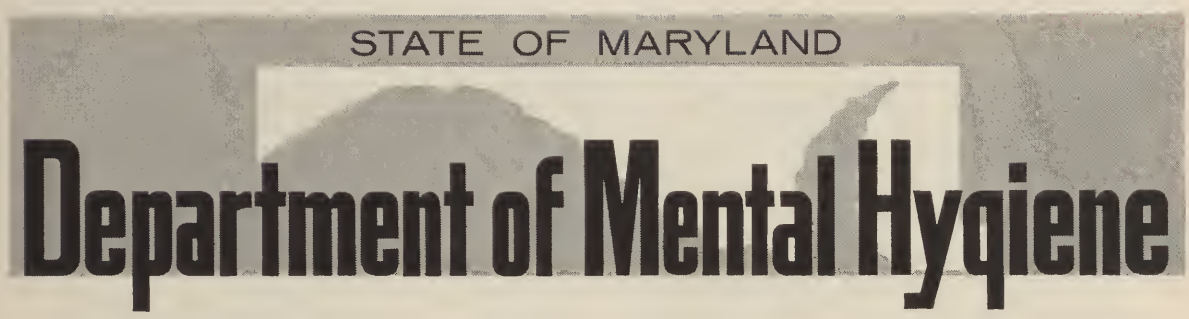
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A REPORT TO THE SIXTEEN SOUTHERN STATES

	Average Annual Per Patient Expenditure		Number Of Employees For Every 100 Patients	
	1958	1964	1958	1964
16 southern states	$1,104	$1,681	26.7	35.7
Rest of United States	$1,589	$2,480	32.3	41.7
Percent difference	—30.5	—32.2	—17.4	—14.2

THE 16 southern states* have made substantial progress in recent years in providing better hospital services for their mentally ill. The table, based on statistics published by the National Institute of Mental Health, shows that despite this improvement the southern states continue to lag appreciably behind the rest of the United States. Further, this gap has not decreased in recent years.

Only Delaware and Maryland exceeded the national average expenditure per patient. Five states were more than 40% below this level. In addition, the southern states in 1964 provided hospital services for a total of 376.8 mentally ill patients for every 100,000 residents while the rest of the country provided for 448.8. Eleven of the 16 states were below the national average. Thus, proportionally, the southern states cared for fewer patients and spent less per patient.

The National Institute of Mental Health reported similar variations in the hospitals for the mentally retarded. In 1964, for example, average annual expenditures per resident patient in the South were one-fifth lower than the average per patient expenditure reported by the rest of the country. The southern states provided hospital services for 72.9 retarded patients for every 100,000 residents; the other states cared for an average of 114.0. Only Delaware and South Carolina exceeded the national average.

This lower level of hospital services is mainly due to the relatively lower economic level of most of the southern states. According to latest figures released by the U. S. Department of Commerce, per capita income in the South is one-fourth lower than in the rest of the United States with all but Delaware and Maryland below the national average. Also, U. S. Census Bureau data show that per capita total general state expenditures were 5.3% lower.

The South has been characterized as an area in transition. In the mental health field, this gradual economic and social development can be expected to produce a continuation of the progress experienced in recent years; however, unless this is greatly accelerated, much of the South will perpetually continue to lag behind the rest of the United States.

Kurt Gorwitz

*Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virgina, and West Virginia.



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Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

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Possibly the most difficult problems of maintaining the asset are: 1) general administrative responsibilities; 2) control of volume at a reasonable level; and 3) retention of a sound financial reward for the knowledge, time, and energy expended.

One might, at this point, ask, "When did I last give my practice a complete physical examination?" If a satisfactory answer can't be found, the next question might be, "How can I best complete the task of giving my practice a quick check-up?"

The use of a Practice Survey Check List will provide insight into trouble areas. The form contains an A to Z listing of the many business responsibilities encountered in a physician's office. It has two columns, headed "Problem" and "Resolved," for use in first locating the trouble areas and, second, to "check it off" once the problem has been resolved.

Copies of the form may be obtained gratis by dropping a note on your office stationery to the *Journal* office asking for a copy of the Practice Survey Check List.

A word of caution—this form, as any similar form, is not the end in itself but only the means through which one can achieve results. The significance of the results will depend on the time and honesty given the appraisal.

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OUR LIBRARY has recently received the 23rd edition, 1965, of the *American Medical Directory,* published by the American Medical Association. This edition is in three parts: Part I, alphabetical index of physicians of the United States; Part II, geographical register of physicians of the United States; and, Part III, explanatory notes, codes, and key numbers.

We also have the 1965/66 edition (volume 12) of the *Directory of Medical Specialists,* published for the Advisory Board for Medical Specialties, Inc., by Marquis-Who's Who. This directory lists physicians and surgeons holding certification by the American Specialty Boards. It is a geographical arrangement by specialties with an alphabetical index.

Physicians, surgeons, other medical specialists, psychologists, educators, and clergymen have contributed to the preparation of the new *Today's Health Guide* published by the American Medical Association.

It is an illustrated 640-page manual of health information containing advice on infant care, sex education, diet, and nutrition, as well as a first aid manual.

If you receive requests from patients (as we do from some of our library patrons) for a factual home health guide, you might recommend this book. Its price is $4.95 prepaid and may be ordered from the AMA.

This month we will be completing our order for new journals. If you have any suggestions, please let us know.

RECENT ACCESSIONS

American Academy of Pediatrics: *Standards and recommendations for hospital care of new born infants.* 1964.

American Association of Medical Clinics: *Group practice: Guidelines to forming or joining a medical group.* 1962.

American Medical Association: *Survey report of school health activities of state medical association.* 1963.

American Men of Science: *The Physical and Biological Sciences.* 11th ed. Vol. 1 (A-C). 1965.

Baltimore General Dispensary: Minutes. 1816-1963. Baltimore, 1965.

Dameshek, William: *Leukemia.* 2d ed. Grune & Stratton, 1964.

Educational Council for Foreign Medical Graduates: *Handbook for foreign medical graduates.* 1965.

International Conference on Avian Tumor Viruses: Proceedings. Durham, North Carolina, 1964. National Cancer Institute, 1964.

Kingsbury, John Merriam: *Poisonous plants of the United States and Canada.* Prentice-Hall, 1964.

Maisel, Albert Q.: *The hormone quest.* Random House, 1965.

Pizer, Irwin H.: *Medical journals in St. Louis before 1900.* St. Louis Medical Society, 1964.

Thomas, Caroline B.: *An index of Rorschach responses.* V. 2. *Studies on the psychological characteristics of medical students.* Johns Hopkins Press, 1965.

U. S. President's Commission on Heart Disease, Cancer and Stroke: Report. 1964.

United Steelworkers of America: Special study on the medical care program for steelworkers and their families. 1960.

Yearbook of dermatology and syphilology. 1964/65.

Yearbook of endocrinology, metabolism, and nutrition. 1964/65.

Yearbook of neurology, psychiatry, and neurosurgery. 1964/65.



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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

Educational Courses for Medical Assistants

The Educational Committee of the Baltimore and Maryland Associations of Medical Assistants has presented its first in a series of courses for members. These courses are being given in preparation for an examination, given yearly in certain cities throughout the United States, for the purpose of earning a valued certificate as Certified Medical Assistant. This examination will cover major subjects such as anatomy and physiology; medico-legal problems; medical ethics and human relations; records and accounting; office skills, and clinical techniques.



Raymond M. Atkins, MD

The course just completed was anatomy and physiology, taught by Raymond Atkins, MD, instructor in anatomy at the University of Maryland and assistant director of medical education at Church Home and Hospital. Dr. Atkins generously donated his time, and classroom space was donated by the Church Home and Hospital. The total enrollment was 25. The lectures were followed by surgical anatomy demonstrations in the hospital dissecting room. This was an unusual experience for most of the students. Full color stereoscopic slides were shown which were truly remarkable. They were compiled by Dr. David Bassett, who spent 15 years developing the series.

These courses are offered free to members of the Baltimore and Maryland Associations of Medical Assistants. All participants found this course to be of great value. Anyone interested in future courses should call Mr. John Komber, chairman of the Educational Committee, at 825-6232.

For information about joining the Maryland Association of Medical Assistants please contact the following:

Mrs. Catherine Kousouris, president
5600 Harford Road
Baltimore, Md. 21214

or

Betty Fern, president-elect
c/o Dr. Harry Kelmenson
2 East Read Street
Baltimore, Md. 21202

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

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MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Mrs. Samuel R. Wells

President, Woman's Auxiliary to the Baltimore County Medical Society



Virginia Wells hails from Minneapolis, where she attended both public and private schools. While attending West Virginia University, she saw her future walking up campus hills with *Gray's Anatomy* under his arm and thought, "That's for me!" They were married a year and a half later.

She came to Baltimore while her husband finished medical school and lived here during his internship and residency. She remembers having a "particular ball" at the interns' quarters at Maryland General Hospital.

From 1930 to 1959 Dr. Wells practiced in Hagerstown. During World War II, Ginny owned and operated a children's apparel shop in Hagerstown.

When her husband died, Ginny returned to Baltimore as coordinator of volunteer activities at Mount Wilson State Hospital, and to this has been added public relations work.

In the past, Ginny was president of the Woman's Auxiliary to the Washington County Medical Society and state chairman of the *Bulletin* and *Today's Health*. She is serving her second term as president of the Baltimore County Woman's Auxiliary and her fourth year as editor of *Hygeia Filiae*.

Mrs. Wells is on the board of directors of the Baltimore County Public Health and Tuberculosis Association; a member of the homemakers

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect – Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:
3 to 6 months–3 mg. (½ tsp.* t.i.d.)
6 to 12 months–4 mg. (½ tsp. q.i.d.)
1 to 2 years–5 mg. (½ tsp. 5 times daily)
2 to 5 years–6 mg. (1 tsp. t.i.d.)
5 to 8 years–8 mg. (1 tsp. q.i.d.)
8 to 12 years–10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) **Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

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committee, Baltimore County Welfare Department; president, Mount Wilson Chapter, Maryland Classified Employees Association; and corresponding secretary of the Baltimore Chapter of the Quota Club. She also belongs to the College Club, Woman's Club of Glyndon, Baltimore Alumnae Chapter of Delta Gamma, and others.

Her children are Samuel R. Wells, Jr., Suzanne Hay Wells, and Richard H. Wells, who are all living in the Baltimore area, and Ginny is the proud grandmother of five children.

COUNTY AUXILIARY NOTES

Mrs. Samuel R. Wells, president of the Woman's Auxiliary to the Baltimore County Medical Association, announced that Baltimore County last year sponsored and started an auxiliary for the Mount Wilson State Hospital. This auxiliary is now fully in operation with the help of Baltimore County Auxiliary members.

Allegany County, Baltimore County, and Washington County Auxiliaries have planned summer picnics which include the entire family.

Montgomery County, which had so much success with its fashion show last year, is inviting all auxiliary members to another one on November 2. If you are interested in attending and would like further information, contact Mrs. James A. Roberts, 8907 Georgia Avenue, Silver Spring, Md.

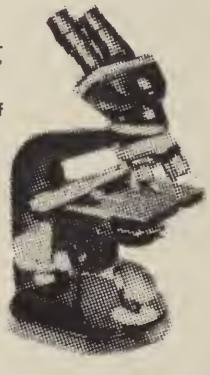
The Washington County Auxiliary, under the presidency of Mrs. Howard N. Weeks, held a theatre party at the Totem Pole Playhouse in June.

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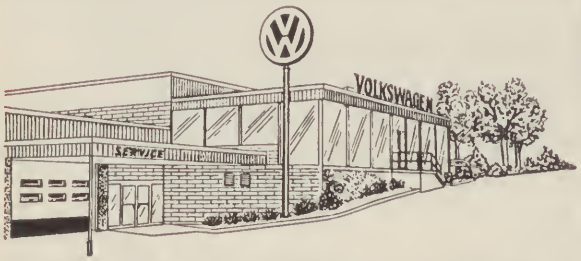
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Book Reviews

FUNDAMENTALS OF ORTHOPAEDICS, by John J. Gartland, MD, Saunders, 1965. $8

This is a basic introductory text intended for undergraduate medical students. It may also be useful for physicians who encounter orthopedic problems occasionally. Coverage of individual entities is intentionally limited, the author's hope being simply to enable the readers to recognize orthopedic disease when they see it and to treat it if it can be done safely and effectively by the non-specialist.

PREVENTIVE MEDICINE: Principles of Prevention in the Occurrence and Progression of Disease, ed 2, edited by Herman E. Hilleboe, MD, and Granville W. Larimore, MD, Saunders, 1965. $12

Preventive medicine has two major phases—preventing the occurrence of disease and disability and preventing their progression. Outstanding specialists in various fields have contributed ways in which the physician and others in the health field can practice preventive medicine.

TEXTBOOK OF OBSTETRICS, by John C. Ullery, MD, and Zeph J. R. Hollenbeck, MD, Mosby, 1965. $17.50.

The authors named and 31 contributors from the Ohio State University College of Medicine have emphasized the problem-solving approach in this text. Nevertheless fundamental methodology has not been neglected as a means of giving students a basic understanding of the principles that will be supplied in problem-solving.

HUMAN SEX AND SEX EDUCATION, Warren R. Johnson, Lea & Febiger, 1963.

The concern of this book is perspectives and problems related to human sexuality and sex education in our society. It is intended to help in the examination and clarification of some of the crucial dynamics of today's world.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, ed 3, by George A. Ulett, MD, and D. Wells Goodrich, MD, Mosby, 1965. $6.75.

This pocket-sized handbook may be used as a brief introduction to psychiatry and as a quick reference for psychiatric residents and others who work briefly in the psychiatric clinic. It may also be of value to the general practitioner, who often is the first to encounter psychiatric problems. Theory is kept to a minimum. Both the table of contents and the index are arranged to aid the user in finding the subject he needs quickly.

SURGERY OF THE BILIARY PASSAGES AND THE PANCREAS, by Walter Hess, MD, D. Van Nostrand Co, 1965. $25.

This is a translation of a comprehensive study of biliopancreatic surgery. Based on statistical evidence from 1,654 biliary patients observed by the author, it emphasizes recent innovations in intra-operative diagnostic techniques.

TRAUMA TO THE LIVER, by Gordon F. Madding, MD, and Paul A. Kennedy, MD, Saunders, 1965. $6.

This is volume 3 in the series "Major Problems in Clinical Surgery." The authors became interested in the subject during World War II, when they were assigned to study injuries to the biliary tract. This book is written from a clinical point of view with much reference to the literature.

MANAGEMENT OF JUVENILE DIABETES MELLITUS, by Howard S. Traisman, MD, and Alvah L. Newcomb, MD, Mosby, 1965. $12.75.

Care of the juvenile diabetic is different from that of the adult diabetic. This book offers a concise, practical method of management of juvenile diabetes mellitus. It is written primarily for pediatricians and general practitioners.

ELECTROCARDIOGRAPHY AND VECTORCARDIOGRAPHY. INSTRUMENTATION, FUNDAMENTALS, AND CLINICAL APPLICATIONS, by Lawrence E. Lamb, MD, Saunders, 1965. $17.

The author sees the electrocardiogram—when properly used—as one of the most valuable tools in the correct assessment of the presence or absence of heart disease. Its value becomes even greater when used in a serial fashion over a number of years. He foresees that electrocardiography will be used to even greater advantage in the future and maintains that future advances can be fostered by thorough understanding of the basic physical principles and their relationship to clinical application. He, thus, in this volume, melds the pertinent information related to the basic physical characteristics involved in instrumentation, vector analysis and cellular physiology and demonstrates the relationship of these fundamental principles to clinical application.

BRAIN FUNCTION, vol 2, RNA AND BRAIN FUNCTION MEMORY AND LEARNING, edited by Mary A. B. Brazier, University of California Press, 1965. $10.

The possibility of similarities between information storage in genetic and in memory processes led to an important meeting of exponents of both these fields. The results of this international conference are offered in the present volume, which is part of the UCLA Forum in Medical Sciences.

In their exploration of the phenomena of memory and learning, the contributors review the state of nucleic acid coding in genetics. They also re-examine some of the earlier attempts to identify such a nucleic acid base for information storage and retrieval in the nervous system. Finally they consider whether or not some of the advances made in genetic coding can be carried over to the processes of memory and learning.

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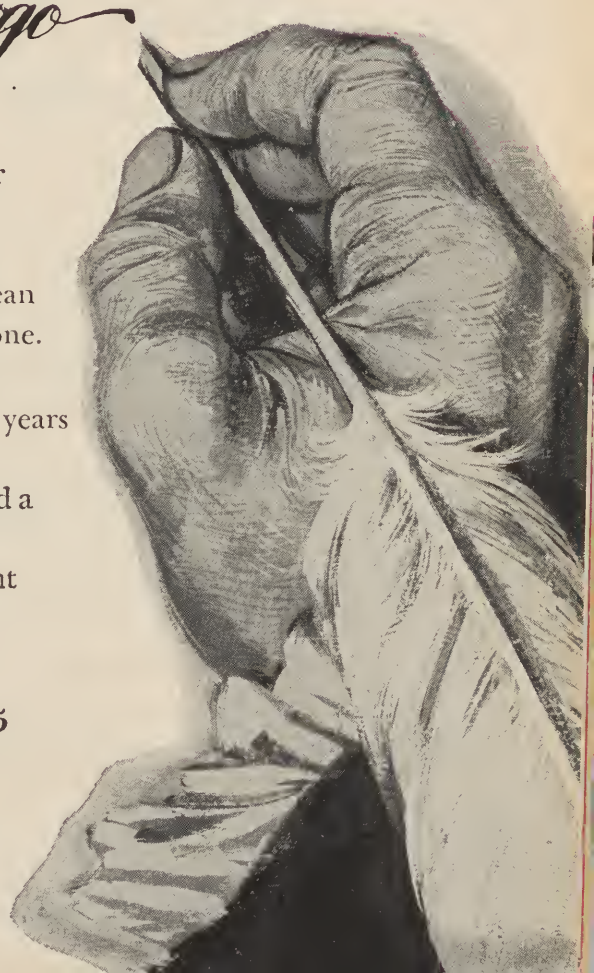
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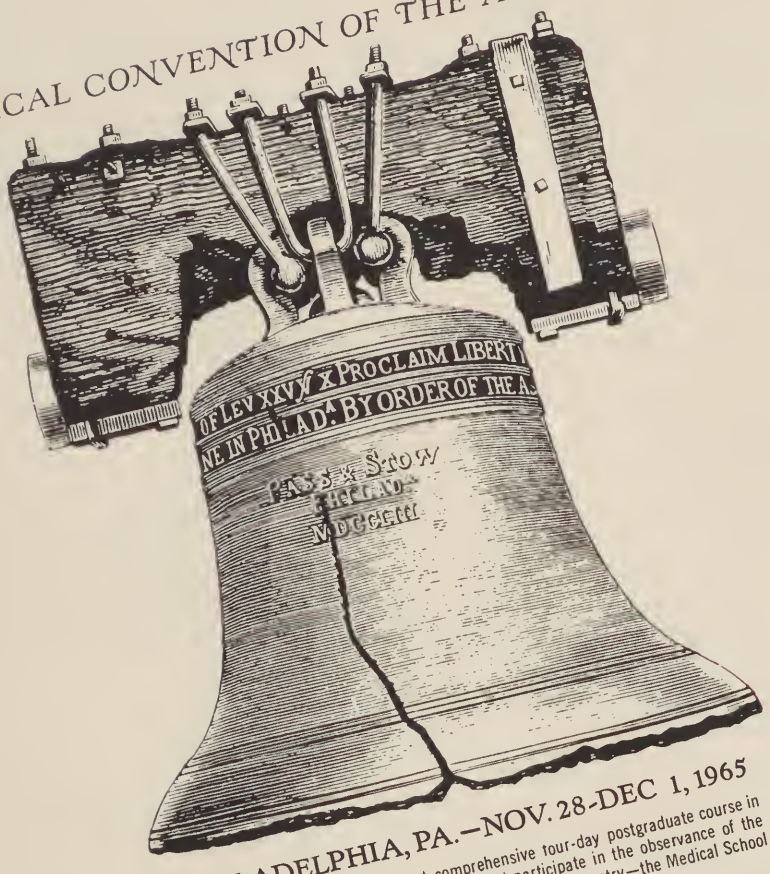
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No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part (Title VI) applies.*

Specifically, it would affect physicians, dentists, and pharmacists articipating in the state's Medical Care Program in that the physician, dentist, or pharmacist may not, on the basis of race, color, or national origin,

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*Reprint from the *Federal Register,* Friday, December 4, 1964.

You will notice shortly on the bills submitted under this program, the following statement: "I certify that I am in compliance with Title VI of the Civil Rights Act of 1964." If a complaint would be filed under this Act, the law requires that an investigation be made.

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Shady Nook Home, Inc., Catonsville
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Dulaney Towson Nursing and Convalescent Home, Towson
House in the Pines—Easton, Easton
Vindobona Nursing Home, Braddock Heights
Avalon Manor, Inc., Hagerstown
Kensington Gardens Sanitarium, Kensington
Magnolia Gardens Nursing Home, Lanham
Resmor Sanitarium and Hospital, Bethesda

Admission to a skilled nursing facility must be within 14 days after discharge from a hospital and it must be for the same or a related condition for which the subscriber received care at the hospital. Benefits in the skilled nursing facility are provided for up to $8 per day or 80% of the actual charges, whichever is less.



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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

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Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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(1) Portnoy, J.; Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS. *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAB., *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.



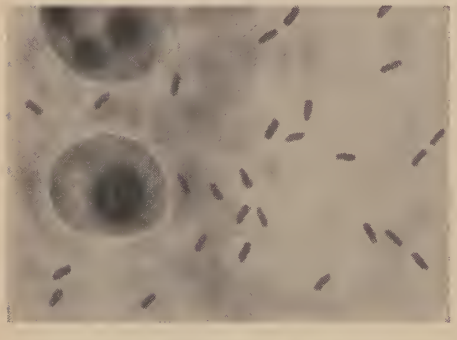
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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Doctors take note...

MARK THESE IMPORTANT DATES ON YOUR CALENDAR

November 28-December 1—AMA Clinical Convention, Philadelphia.

April 27-May 4, 1966—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland. April 27-28, Baltimore—April 29-May 4, Aboard ship and in Bermuda

BALTIMORE CITY MEDICAL SOCIETY

December 3—7:30 PM—1211 Cathedral St., Baltimore

Annual business meeting and election of officers. The doctors are cordially invited by the Woman's Auxiliary to the Baltimore City Medical Society to join them for refreshments and entertainment after the meeting of the Society. Polls open 9 AM to 9 PM, 1211 Cathedral Street.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

December 7—7:30 PM—1211 Cathedral St., Baltimore

Leroy D. Vandam, MD, Peter Bent Brigham Hospital, Boston, will be the guest speaker.

MARYLAND PSYCHIATRIC SOCIETY

December 16—Seton Psychiatric Institute

"Geriatric Psychiatry," Ewald W. Busse, MD, Professor of Psychiatry, Duke University School of Medicine. Discussant, Myron Eichler, MD.

ACP POSTGRADUATE COURSES

Course No. 8—"Psychiatry for the Internist." December 6-10, University of Southern California School of Medicine.

Course No. 9—"Medicine of Tomorrow: Recent Advances in Internal Medicine." January 10-14, University of Alabama Medical Center.

Inquire: Edward C. Rosenow, Jr., MD, executive director, The American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

UNIVERSITY OF MARYLAND POSTGRADUATE COURSES

4. SURGICAL PHYSIOLOGY—December 16

Under direction of Arlie R. Mansberger, MD: Preoperative and postoperative physiology, functional derangements, and management of the clinical problems commonly presented by the surgical patient.

5. ADVANCES IN MEDICAL SCIENCE—January 12-March 30

Designed for physicians in practice who wish to review the important advances in medical science. Emphasis is placed on a basic scientific approoch to an understanding of the more common clinical problems and their management.

6. DERMATOLOGY DAY—January 20

Under direction of H. M. Robinson, Jr., MD: A clinical session in which many dermatologic disorders will be seen and examined by the attending physicians, followed by presentation and discussion of the problems of diagnosis and management of each entity.

7. CLINICAL ANATOMY—February 2 through May 25

Under direction of Otto C. Brantigan, MD: Emphasizing the proctical application of anatomy and anatomical principles in physicol and x-ray diognosis. Anatomicol knowledge is related to the use of needling in performing diagnostic procedures and in treatment. The course is directed toward both the medical mon and the surgeon. It is an oid in preporation for the Americon Board Exam.

8. OBSTETRICS—February 10

Under direction of Edmund B. Middleton, MD: Problems of obstetrical management in the prenotal period ond ot the time of delivery will be considered.

9. HEMATOLOGY—Morch 10

Under direction of Carroll L. Spurling, MD: A basic review of diseases of the hemopoietic system. Illustrative peripheral blood and bone morrow slides will be used in connection with selected case moterial. Newer techniques of diagnosis and treatment will be discussed.

MEDICAL ASPECTS OF SPORTS

November 28—Benjamin Franklin Hotel, Philodelphia

Seventh national conference sponsored by AMA will cover a wide range of subjects of interest to physicians, especially those serving school and college sports progroms. Included will be papers, panels, and discussions relating to readiness for sports participation, monogement of health problems in sports, and opplicotion of research to injury prevention. For further informotion, write to Secretory, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

SYMPOSIUM ON COCCIDIODOMYCOSIS

December 8-10—Phoenix, Ariz.

Second nationol symposium. For further informotion write to Arizono Tuberculosis and Health Association, Inc, 733 West McDowell Rood, Phoenix, Ariz. 85007.

HAHNEMANN POSTGRADUATE COURSE

December 8-10—Sheraton Hotel, Philadelphia

Hahnemann Symposium, "New Concepts in Gynecologicol Oncology," directed by George C. Lewis, MD.

Conference on Maryland's Community Mental Health Plan

DECEMBER 8

10 AM-4:30 PM

SHERATON BELVEDERE HOTEL,

BALTIMORE

10 AM

Keynoter: John C. Whitehorn, MD
"MARYLAND'S COMPREHENSIVE COMMUNITY MENTAL HEALTH PLAN"

11 AM

Regional Discussion Groups

2:30 PM

Panel Discussion: "THE COMMUNITY MENTAL HEALTH SERVICES ACT — KEY TO IMPLEMENTING THE PLAN"

4 PM

Conference Summary: Joel Elkes, MD, Director, Department of Psychiatry, Johns Hopkins University

The luncheon address will feature an internationally known authority, to be announced.

CONFERENCE PLANNING COMMITTEE

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NOVEMBER, 1965

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for the

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The Alcazar-April 27 and 28, 1966

Bermuda Cruise-April 29-May 4, 1966

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Dr. Gustave J. Dammin, Peter Bent Brigham Hospital
Dr. James G. Hirsch, The Rockefeller Institute
Dr. Rudolph H. Kampmeier, Vanderbilt University
Dr. Donald G. McKay, Columbia University
Dr. John F. Mullan, University of Chicago
Dr. John Parks, Dean of The George Washington University School of Medicine
Dr. Alan S. Rabson, National Institutes of Health
Dr. H. Curtis Wood, Jr., Medical Field Consultant for The Association for Voluntary Sterilization.

The first lecture in memory of Dr. Amos R. Koontz will be given jointly by **Dr. Robert W. Buxton,** Professor of Surgery at the University of Maryland, and **Dr. Walter F. Ballinger, II,** Associate Professor of Surgery at The Johns Hopkins. **Dr. Houston S. Everett,** Associate Professor of Gynecology and Obstetrics at The Johns Hopkins, will give the fifth annual Hundley Lecture in gynecology. A symposium on the Relationship of Alcoholism and the Law will be held on Wednesday evening, April 27. This will prove most informative from both the medical and legal viewpoints.

The House of Delegates will meet in the Faculty Building on TUESDAY, APRIL 26, and FRIDAY, APRIL 29.

During the cruise, lectures will be presented by **Dr. Ernest I. Cornbrooks, Jr., Dr. Frank A. Faraino, Dr. Karl F. Mech, Dr. Moses Paulson, Dr. Richard N. Peeler,** and **Dr. Jonas R. Rappeport.**

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Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Also available:
Butazolidin®
brand of phenylbutazone
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PHYSICIANS VIOLATING SECTIONS 146, 147, and 148 OF THE MEDICAL PRACTICE ACT

Recently we have had a number of cases involving advertising by physicians which is in violation of the Medical Practice Act, Sections 146, 147, and 148.

All physicians licensed in the last eight or ten years have received a copy of the *Law Regulating the Practice of Medicine in Maryland,* and they have been instructed to familiarize themselves with the contents.

SECTION 146

All advertising by all persons practicing medicine and surgery in this State is prohibited except the following:

(a) A physician or surgeon may use a personal professional card of not more than 3½" × 2", upon which may be printed only his name, title, address, specialty, telephone number, and office hours.

(b) Removal notices may be mailed by any physician or surgeon notifying any bona fide patient of said physician or surgeon that he is removing his offices from his present address to the address set forth on said notice. Such notice shall not be more than 5" × 7" and may only contain the name, title, specialty, telephone number, office hours, and new address and old address.

(c) Each physician or surgeon may exhibit on the door or wall of the building wherein he practices not more than two signs on which may be placed the name and title or degree of such person, and his specialty, the letters of which shall not exceed three inches square. In addition he may exhibit such sign on the door of his office in addition to those on the door or wall of such building.

SECTION 147

Any person practicing medicine or surgery who shall solicit or advertise by mail, card, newspaper, pamphlet, radio or otherwise to the general public, except as set out in Section 146, shall be guilty of a misdemeanor, and upon conviction thereof shall be fined not less than $50 nor more than $300 for each offense. Provided, however, that notices by mail to bona fide patients of times for periodic examinations shall not be construed as soliciting or advertising.

SECTION 148

A violation of the provisions of Sections 146 or 147 shall constitute unprofessional conduct and the license of any physician or surgeon guilty of such violation shall be subject to revocation as set out in Section 145 of this article.

Frank K. Morris, MD, Secy
Board of Medical Examiners
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"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

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So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



RESOLUTIONS

Adopted by Joint Committee on Health Problems in Education, National Education Association–American Medical Association, March 28-30, 1965.

ORIENTATION OF PHYSICIANS: SEX EDUCATION OF PATIENTS

Whereas, the American Medical Association, through its House of Delegates, has expressed concern with respect to the need for medical counseling of patients on sexual attitudes and behavior, and

Whereas, the AMA Committee on Maternal and Child Care and the AMA Committee on Human Reproduction have made recommendations urging increased emphasis on orientation of physicians concerning patient education relating to sexual attitudes and behavior, and

Whereas, physicians frequently serve as resource persons in this area of health education in schools, colleges, and other youth agencies, therefore be it

Resolved that the Joint Committee on Health Problems in Education commend these committees and all others concerned on their action in recommending increased emphasis on orientation of physicians in the area of sexual attitudes and behavior in the curricula of medical schools, and be it further

Resolved that all medical schools and programs of continuing medical education give consideration to incorporating appropriate learning experiences for physicians in the area of counseling relating to sexual attitudes and behavior.

HEALTH EDUCATION

Whereas, the Joint Committee on Health Problems in Education has expressed its concern for the need for effective health education periodically since 1911, and

Whereas, this concern has also been voiced by the American Public Health Association School Health Section, the American School Health Association, the American College Health Association, and others, and

Whereas, major health problems affecting this country have brought renewed emphasis on this subject, therefore be it

Resolved that the U. S. Office of Education, state departments of education, school boards, and school, college and university administrators become more fully aware of the importance of health as a goal for education, and be it further

Resolved that the Joint Committee on Health Problems in Education give encouragement and recognition to agencies conducting research into more effective health education, and be it further

Resolved that teacher preparation institutions recognize the importance of health education as an academic subject and to provide for majors in this field for the certification of teachers to serve the schools.

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EXECUTIVE SECRETARY'S NEWSLETTER

November, 1965

RESOLUTIONS

Resolutions for consideration at the Faculty's Annual Meeting, April, 1966, must be in the Faculty office before MARCH 1, 1966, in order to be considered. No date has been set as yet for the Reference Committee hearing.

INDIVIDUAL PHYSICIANS MAY TESTIFY ON AMA MATTERS

Contrary to what most physicians believe, it is permissible and highly desirable that individual physicians express their opinions on matters that are under discussion by the American Medical Association's House of Delegates.

All matters are referred to Reference Committees where they are discussed in detail. Individuals, as well as physician-members of the AMA, are encouraged to speak on matters in which they are interested.

The Faculty's Delegates have a headquarters suite at the Philadelphia-Sheraton Hotel, where members from Maryland may make contact with the AMA delegates and offer suggestions or comments, November 28 through December 1.

ALERT FOR PHYSICIANS

It has come to our attention that copies of Medical Economics, JAMA and other such periodicals are finding their way to physicians' waiting rooms. Probably most physicians are not aware of this.

When one considers the content of this type of publication, it appears obvious that this is not a wise practice. If you agree, won't you check your waiting room and alert your secretary to this?

NEWS NOTES

August Daniel King, Jr., M.D., and Salvatore J. Demaroo, III, M.D., have been certified by the American Board of Surgery.

New Fellows of the American College of Surgeons inducted at the annual meeting in Atlantic City include: R. Robinson Baker, Odom N. Coker, John A. C. Colston, Jr., John C. Dumler, Joseph H. Hooper, Jr., Robert E. Martin, Frederick W. Plugge, IV, and Archie

Robinson, Jr., all of Baltimore; Stephen B. Hiltabidle, Annapolis; Lindsay C. Getzen, Paul D. Mozley, Ayub K. Ommaya, Bethesda; and William A. Holbrook, College Park.

Recently certified as a Fellow of the American College of Anesthesiology are: Thomas C. McAslan, Baltimore; and Jerry A. Phelps, Wheaton.

CORRECT USE OF TERMS

Because the term, Medicare, has become known as the plan for people over age 65, the Office of Dependent's Medical Care for members of the U. S. Armed Forces has designated its program to be known as Dependents' Medical Care Program.

Physicians should become used to this term for this program so as to avoid confusion by the fiscal administrators.

SPECIAL STUDY AND TREATMENT

Edward F. Lewison, M.D., Chief of the Breast Clinic, Johns Hopkins Hospital, has advised that the Clinic is anxious to have patients with advanced, recurrent or metastatic breast cancer referred to the clinic for special study and outpatient treatment.

Under the USPHS Cancer Chemotherapy Research Grant all expenses for outpatient care will be defrayed by the Breast Clinic provided the patient qualifies for hormone therapy.

Physicians should contact Dr. Lewison at 955-5060.

COMPONENT VISITS

Visits to Component Medical Societies are currently underway by Faculty staff. Recent visits have been made to Montgomery, Harford, Charles, Prince George's and Wicomico Counties.

It is interesting that the Harford County meeting was well-attended, by invitation, by members of the Medical Corps, U.S. Armed Forces.

John Sargeant

Executive Secretary



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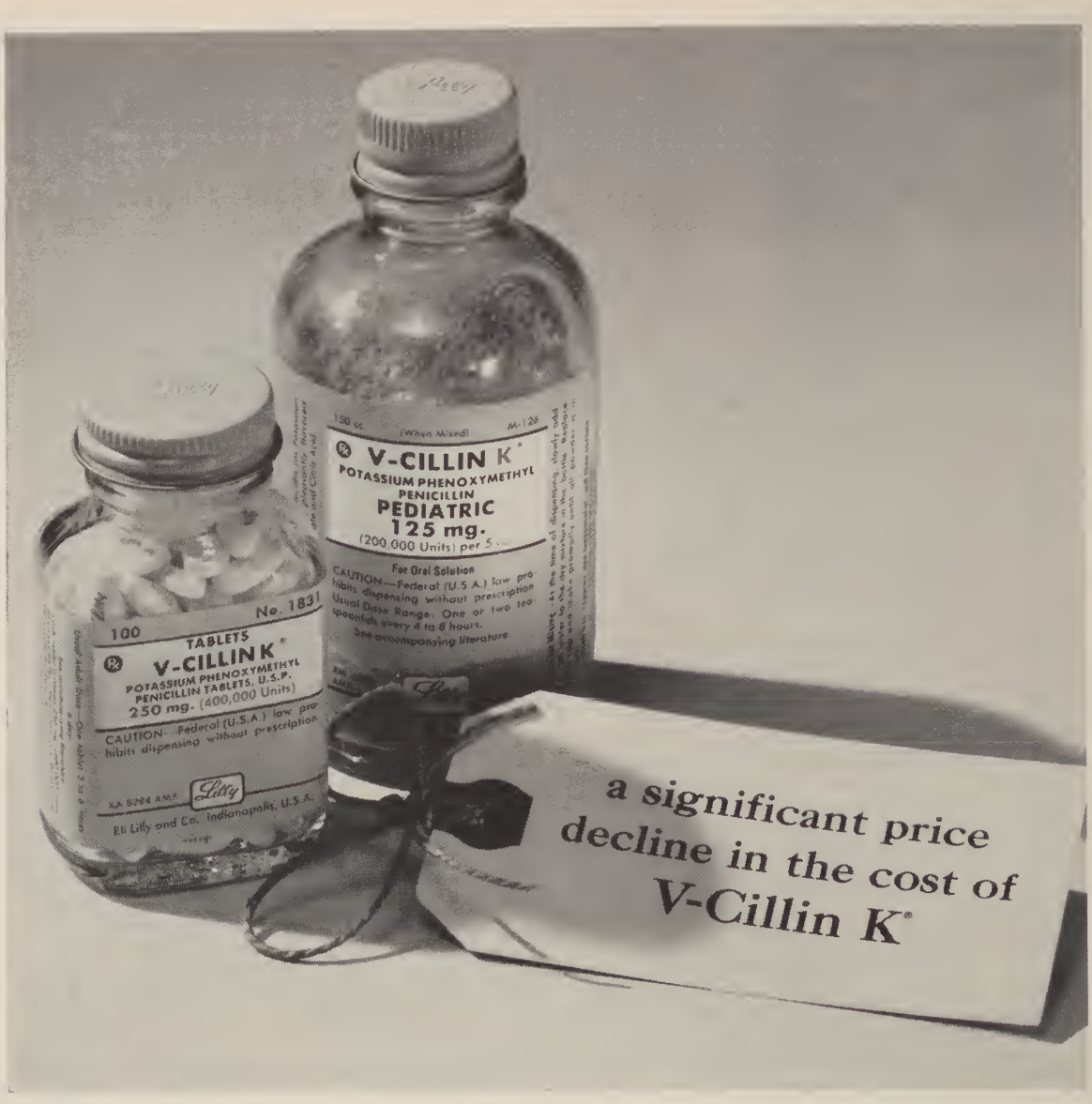
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Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

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Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana.

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Maryland State Medical Journal
Vol. 14, No. 11
November, 1965

Editorial

THE CONSULTATION AND THE CONSULTANT

SAMUEL MORRISON, MD
President, Baltimore City Medical Society

What has happened to the consultant and the consultation? I recall such men as Dr. Thomas B. Futcher, Dr. Louis Hamman, Dr. William S. Thayer, Dr. Charles Austrian, and others who, in a past era, spent an hour or more conferring with the patient's physician, carefully questioning the patient, and doing a detailed examination. They used their analytical minds and their "six-plus" senses in interpreting the carefully placed murmur, the incipient enlargement of an organ, or some other abnormality such as a pulsation in the neck or a slightly engorged vein. At the same time they evaluated the patient's emotional make-up and perhaps the significance of the household surroundings. These men were recognized not only for their capabilities but also for their ability to make a reasonable diagnosis and to offer suggestions which would benefit both the conferring doctor and the patient.

Today, the consultant is no longer distinguished by his special faculties. Blue Shield, for example, allows anyone of any age or experience or training to be designated as a consultant. Many consultants today do not use their God-given faculties. Instead they suggest more examinations, sometimes very expensive and complex. They keep depositing requests into the hopper awaiting an answer. The more esoteric the request, the higher the pinnacle of brilliance attributed to the so-called consultant, and he is rewarded in admiration for thinking of something which is not there.

At the other extreme is the consultant who has not bridged the gap between the former era when many tests were not available and the present with many remarkable diagnostic methods. He has not learned that many of these examinations are important and should be used. Only recently a patient with severe disability and pain from arthritis was seen by a consultant who said that it was unnecessary to do any x-rays but simply recommended proceeding with treatment. He had, however, at the same time concurred in various blood examinations. He may have been right, but neither the patient nor his family would understand why a painful large joint should not have the benefit of an x-ray, nor would his family doctor understand why in a hospital environment



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certain studies should not be accomplished and documented.

A consultant must be alert to changes. We all need a philosophy, a set of values, so that we can agree on what is important. As an example, how many electroencephalograms are positive compared to the number ordered? How many of the various scans are positive, making the same comparison? These are expensive examinations. In the instance of the electroencephalogram, the large number of negatives suggests either that the test is not indicated or that it is being done to impress or for some other justification. Repetitious requests are also a mark of our times. For example, how many electrocardiograms are enough? Are there not other measurements of the course of the ailment? What of the cost involved? What of the iatrogenic trauma which often results?

I was surprised recently when a doctor who does consultation work expressed his admiration for another doctor who, on the basis of a lachrymal gland biopsy, made a certain diagnosis. As admirable as this is (or is it?), the fact is that care in making a common diagnosis may be more important to more doctors and patients than the occasional, perhaps untreatable, rare diagnosis.

Sometimes a consultant's greatest contribution is to teach the patient how to live with a condition. What is more important, the breast tumor and its removal or the trained humanitarian physician who can teach the patient to live without fear? Each, of course, has its place.

A consultation can be a valuable document but never without a consultant who combines the training of the Oslerian clinician with acumen in selecting modern procedures which will help him arrive at his conclusion. The number of studies and the use of gadgets are being overdone, and they should be brought to a responsible level. There is a point of diminishing returns.

A statement in the September, 1965, issue of *Better Homes and Gardens* caught my eye. It reads in part, "However, it is important to remember that thorough, accurate examination results depend not so much on automated test equipment as on the perceptiveness of the examining physician."

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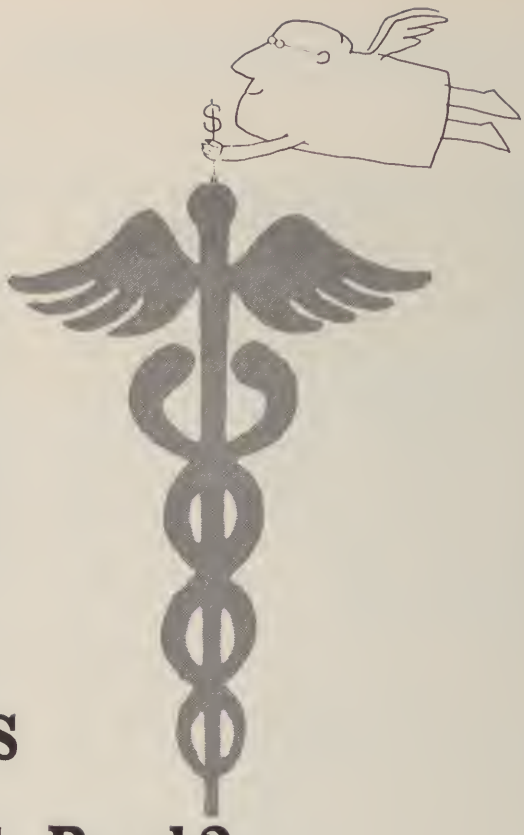
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JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, SEPTEMBER 9

1. Financial operating statements for May, June, and July were approved. The related special fund statement was approved through July 31.

2. Appropriate action was taken on salaries of personnel who were eligible for salary review.

3. Revised job classifications and salary ranges were approved. At the same time, a statement was adopted concerning remuneration from sources outside the Faculty for work done outside regular working hours.

4. Approval in principle was given to the proposal that MMPAC dues be sent out along with Faculty dues bill. This action can be rescinded if circumstances deem it necessary.

5. A letter is to be sent to all members who have not paid the $50 assessment. This letter will explain as fully as possible the expenditures of funds raised from the assessment and will include data as to the deductibility of it in computing net taxable income.

6. Correspondence was received from the State Health Department advising that rules and regulations for registration of laboratories doing clinical work in the state are under revision. The Faculty will be provided with a copy before they are adopted.

7. Approval was given to distribution to the membership of a "Presidential Letter" as needed.

8. Raymond L. Clemmens, MD, was recommended for reappointment to the Advisory Council on Mental Hygiene for a three-year term.

9. Mr. Walter Kirkman is to be asked to review the proposed health code revisions. If he is unable to do this, someone else outside of the Faculty office is to be sought for this project.

10. Opinion was expressed that the Faculty should make known its views in connection with the Eastpoint Medical Center's filing with the Insurance Commissioner. The Faculty usually has no objection to the operation of such a "closed panel" program as long as the individual patient may decide whether or not to participate.

11. The medical assistants group was granted permission to use the Faculty building for a series of lectures on medical law. This was subject to prior use of the auditorium by other medical groups and the understanding that they might have to use another portion of the building if the auditorium is otherwise needed.

COUNCIL, SEPTEMBER 9

1. Legal defense was approved for various members in good standing.

2. Legal counsel was retained for a one-year period.

3. Approval was given to budgeting a sum of money in 1966 to have 50-year membership pins made.

4. The AMA delegates were authorized additional funds to maintain a hospitality suite at the AMA clinical session in Philadelphia. This will be headquarters for Maryland members attending the meeting. No food or drink will be dispensed.

5. On recommendation of the Mediation Committee, the following policy statement was reaffirmed:

> "The Medical and Chirurgical Faculty of the State of Maryland is unalterably opposed to the denial of membership privileges and responsibilities in component medical societies to any duly licensed or qualified physician because of race, color, religion, ethnic affiliation, or national origin; and
>
> "The Medical and Chirurgical Faculty of

the State of Maryland calls upon all component societies and all individual members of the Faculty to exert every effort to end every instance in which such equal rights, privileges or responsibilities are denied."

6. For the third consecutive year, the program for treatment and rehabilitation of alcoholics at the Eastern Health District clinic was approved.

7. On recommendation of the Medical Emergency Disaster Committee, the following approvals were granted:

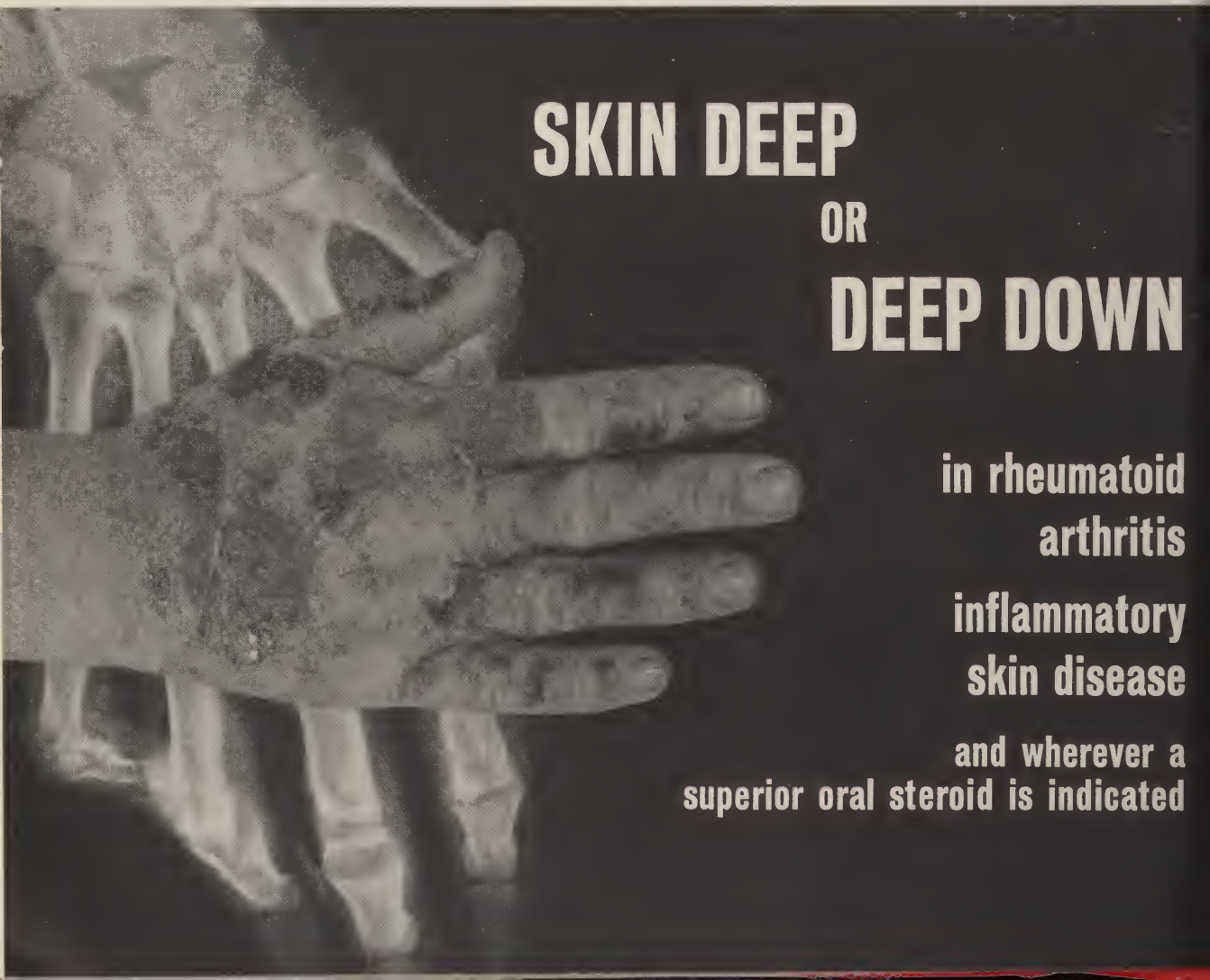
(a) The Council go on record as urging all hospitals in the state to institute prompt measures to assure compliance with the "two disaster drills" per year requirement of the Joint Commission on Accreditation of Hospitals. This might be done by correspondence with all hospitals, by a notice in the *Journal* or both.

(b) The Council go on record as endorsing the combining of the Emergency Room Committee and the Medical Disaster Committee to make them an active part of all hospital staffs. This is a new concept and is rapidly becoming popular in other parts of the country.

(c) The Council make such a recommendation to the hospitals in Maryland and that such be included in the staff planning of the hospitals.

8. The following actions of the Economics and Executive Committees were approved:

(a) The proposal on insurance as recommended by the Economics Committee for a Faculty-administered insurance program of accident and sickness insurance and major medical insurance be approved; and that the Faculty advance the necessary funds for the program's operation



with the understanding that these funds will be repaid; and that salary policy be developed to provide for the proposals as offered by the Economics Committee.

(b) The Council approved the preparation of an appropriate trust agreement by the Faculty's legal counsel, the expense of which will be paid by the insurance "loading charge," and that such a trust will be called the "Med-Chi Insurance Trust"; and that adequate provisions be made for 1) any amendment in the trust agreement be subject to approval by the Faculty's Council and 2) the trustees be empowered to carry out the duties and responsibilities of such a trust agreement including designation or change of any agent of record.

9. Approval was given to the proposal of the Glaucoma Service and Research Department of the Wilmer Ophthalmological Institute of the Johns Hopkins Hospital for research and community service. A screening program for adults over 25 years old is to be held in the Luthervile-Timonium area.

10. The Council upheld the action of the Public Relations Committee in disapproving a request of the Wicomico County Medical Society for funds in connection with their 1965 tetanus immunization drive. Wicomico County had not sought prior approval for such funds.

EXECUTIVE COMMITTEE, SEPTEMBER 23

Maryland Medical Service, Inc. was chosen as the Faculty's fiscal agent for operation of the Medicare program in Maryland. This information is to be communicated to the secretary of Health, Education, and Welfare of the United States.

Council members are to be polled on this action to be sure that it is in order.

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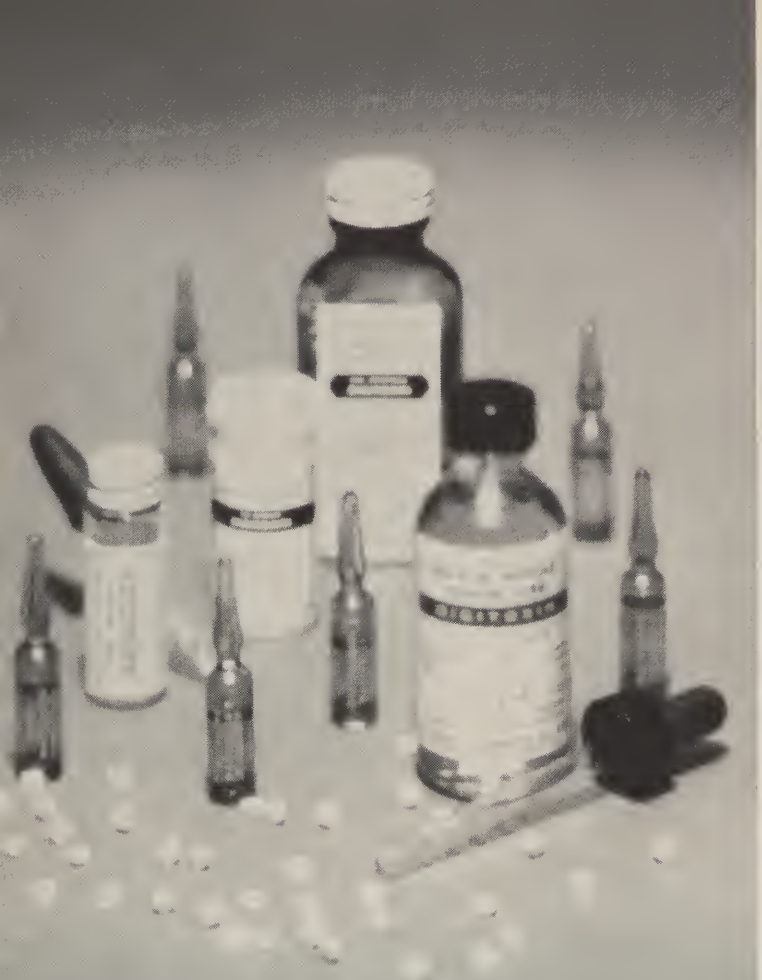
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and trunk, balanced precariously on a
insufficient base, result in strain of th
dorsal musculature, particularly at th
low lumbar level.

*The unusual muscle-relaxant and anal
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cially useful in the treatment of low back
sprains and strains. 'Soma' is widely
prescribed ☐ **to relieve pain** ☐ **to relax
muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of
muscle spasm, pain, and stiffness in a variety of
inflammatory, traumatic, and degenerative muscu-
loskeletal conditions. It also may act to normalize
motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reac-
tions to carisoprodol.

Precautions: 'Soma', like other central nervous
system depressants, should be used with caution
in patients with known propensity for taking ex-
cessive quantities of drugs and in patients with
known sensitivity to compounds of similar chemi-
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with any
frequency is sleepiness, usually on higher than
recommended doses. An occasional patient may
not tolerate carisoprodol because of an individual
reaction, such as a sensation of weakness. Other
rarely observed reactions have included dizziness,
ataxia, tremor, agitation, irritability, headache, in-
crease in eosinophil count, flushing of face, and
gastrointestinal symptoms.

One instance each of pancytopenia and leuko-
penia, occurring when carisoprodol was admin-
istered with other drugs, has been reported, as has
an instance of fixed drug eruption with carisoprodol
and subsequent cross reaction to meprobamate.
Rare allergic reactions, usually mild, have included
one case each of anaphylactoid reaction with mild
shock and angioneurotic edema with respiratory
difficulty, both reversed with appropriate therapy.
In cases of allergic or hypersensitivity reactions,
carisoprodol should be discontinued and appropri-
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depression.

Dosage: Usual adult dose is one 350 mg. tablet
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Supplied: Two Strengths: 350 mg. white tablets
and 250 mg. orange, two-piece capsules.

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RECENT ADVANCES IN UROLOGY AND THEIR RELATION IN GENERAL PRACTICE

THEODORE R. FETTER, MD

The tremendous advancements in urology have influenced the diagnosis and management of urologic disease. The importance of these factors is noted in the various resident training programs throughout the country. Most of the recent urologic advances are being made by comparatively young urologists. The significance of these continuing investigations will obviously be felt by all urologic surgeons. It is almost necessary to have, in addition to clinical experience, a solid foundation in the basic disciplines of physiology, biochemistry, and pharmacology. Surgical innovations continue to be reported, as noted in urinary diversion techniques. The crux of the present situation is to be able to report the experimental, investigative studies and to translate them into practical clinical application. Ultimately, the restoration of an abnormal urinary tract to a normally functioning urinary system is the desired result.

THE SPECIALTY OF UROLOGY has not remained static. Recent advances in urologic surgery have excited general interest everywhere, not only among physicians but also the public. For example, the greatest interest is in kidney homotransplantation. This problem, together with improved techniques in urinary diversion, has rekindled the interest of the general surgeon and urologist to work more closely than before. Indeed, this is reflected in our resident training programs. Basic research in urology is making tremendous strides in advancing and changing the thinking in many urologic facets. Methods of teaching and interrelationship of our specialty with other disciplines have encouraged changes in the medical curriculum. The basic science group are no longer isolated from the clinical departments. This is exemplified by a check of scientific programming. It is obviously impossible to mention every advancement in urology and its portent on clinical practice, but an effort will be made to discuss several topics which appear to be somewhat controversial and yet important for presentation to a group of physicians on the home front.

URINARY INFECTION

During the past several years a tremendous number of papers dealing with urinary infections have appeared. These reports have been concerned primarily with newer concepts of pathogenesis, with means of enhancing diagnostic methods, and with the therapeutic efficacy of various antibacterial agents. While most reports conclude that obstruction of the urinary passage represents the most important factor favoring infection, a serious danger has arisen with the widely published opinion of certain workers that many urinary infections arise on a nonobstructive basis. Analysis of the clinical data presented by these workers invariably reveals that obstruction was, in fact, not ruled out in most instances. The resistance of the normal urinary tract to infection has been demonstrated,

Presented before the Medical and Chirurgical Faculty of the State of Maryland, April 22, 1965.

From the Department of Urology, Jefferson Medical College, Philadelphia.

although the mechanism is as yet unknown. That intrinsic defects in this resistance may permit infection to occur in the absence of obstruction has been postulated, but the evidence thus far is inconclusive. A vast body of experimental and clinical evidence emphasizes and reinforces the well established principle that urinary infection usually means an obstruction is present.

It is likely that in many instances the erroneous classification of urinary infections as "nonobstructive" has resulted from misplaced reliance on the intravenous urogram. Urologists recognize that the intravenous urogram may remain entirely normal in the presence of definite surgically correctible obstructive lesions. It is obvious that failure to demonstrate residual bladder urine does not necessarily indicate a normal urinary tract; the bladder detrusor muscle may be compensating for distal obstruction. While many obstructions may be revealed on urography in the form of impaired renal function or gross dilatation, impaired emptying, subtle or occult obstruction may not be evident. These relatively obscure lesions, sometimes representing urinary tract malfunction rather than anatomic abnormalities, require more sophisticated diagnostic methods than intravenous urography alone.

Judicious use of the usual urologic methods of investigation, including cystoscopy and retrograde pyelography, remain essential in evaluating patients with urinary infection. Modifications of intravenous urography, as by doubling the dosage of contrast medium or using a rapid drip infusion method, have enhanced certain aspects of radiographic diagnosis but have by no means replaced retrograde pyelography, despite unsubstantiated claims to the contrary. Retrograde pyelography is still the most accurate means available for delineating upper urinary configuration and conduction activity. It also affords a valuable opportunity for the collection of urine from the renal pelvis for bacterial and other analyses. While the possibility of infection after instrumentation is recognized, prophylactic chemotherapeutic and antibacterial therapy has reduced this risk to the point that the benefits of diagnostic instrumentation vastly outweigh the possible difficulties.

The urologists have been stimulated to study the entire pattern of urine conduction in normal and abnormal states. From this interest, several more sophisticated diagnostic techniques have evolved, as alluded to earlier. By means of intraluminal pressure studies of the renal pelvis, ureter, and bladder, and by cineradiographic visualization of the entire urinary system, enormous insight has been gained in the area of urinary tract obstruction. It has been noted that hypertrophy of the ureteral musculature occurs in response to obstruction, with subsequent compensatory hyperactivity of the ureter in the same manner as compensatory hypertrophy of the detrusor muscle of the bladder occurs with prostatic obstruction. These compensatory changes may not be demonstrated by intravenous urography. There is no evidence of hydronephrosis or hydroureter until ureteral decompensation has occurred. Thus the usual radiographic depiction of upper tract dilatation often represents a late stage in obstructive uropathy; earlier stages cannot be detected by urography. These mechanisms of compensation have been known relative to stricture of the urethra and prostatic obstruction for many years. Only with the application of sensitive pressure studies and cineradiography have these mechanisms been shown to apply to the upper urinary tract as well. These newer techniques have become extremely useful in the detection and analysis of obstructive disease of the lower urinary tract in children with enuresis, in adults, in problems of incontinence and vesico-ureteral reflux, and most recently in the diagnosis of various adynamic states of the ureter.

It is apparent that the presence of urinary infection warrants a thorough and persistent search for obstruction and that routine methods may not suffice. Intravenous urography alone is clearly inadequate. Blanket acceptance of urographic reports will allow many cases of urinary infection to flourish despite antimicrobial drugs. The recognition of obscure, minute obstructions in the urethra and vesical orifice, particularly in children and in women, as well as more obvious lesions, is essential. Simple dilatation of the urethra, meatotomy of the external urethral meatus, transurethral resection of the vesical orifice, or suprapubic Y-V plasty of the vesical orifice often brings about disappearance of previously resistant infections. Drainage of the urinary tract by catheter or surgical drainage of the bladder or kidney remain invaluable therapeutic measures when judiciously implemented.

The need for thorough urologic evalution of the urinary tract infection is clear. A tremendous op-

portunity presents itself for preventive, as well as therapeutic urology. Better understanding and closer communication among all medical disciplines concerned with urinary infection is urgently needed. Urologists, by virtue of their special training, are willing and able to furnish the required guidance and leadership in this important area of clinical disease.

CHRONIC RENAL FAILURE

The renal disease program is usually run by a group of physicians interested primarily in acute and chronic renal failure, renal hypertension, renal transplantation, hemodialysis, and peritoneal dialysis. They are commonly referred to as the "renal team." The formation of this team was an aftermath of the artificial organ group. It brought clinical experimentation directly into the hospital area. The management of renal failure requires a diversity of interests, both basic and clinical. Inclusion of a urologist is essential for obvious reasons. Frequently it is the urologist who first sees the patient, primarily to rule out obstructive disease in cases of oliguria or anuria. In renal failure, whether acute or chronic, of the post-renal type, the role of the urologist is life saving. Bilateral ureteral obstructions are common. The presence of a solitary kidney with calculous obstruction is not rare; bilateral calculous disease, bilateral pyelonephritis with obstruction, suppuration, hydronephrosis, prostatic obstruction, urethral stricture, congenital obstructions from external meatus to kidney, and surgical accidents such as ligation of both ureters will produce post-renal failure.

Diagnostic procedures must be done in an orderly fashion. Frequently it is difficult to obtain an accurate history, particularly in the acute case. The significance of a scout film of the abdomen should be appreciated. It will disclose opacities which may be obstructing calculi. One must consider the possibility of non-opaque calculi. The presence of renal mass or relative size of kidneys can be determined. Congenital hypoplasia, unilateral or bilateral, does occur. One may even note such a common finding as a distended bladder due to long-standing prostatic or urethral obstruction.

The question of obtaining an intravenous urogram frequently comes up for discussion. It would seem important to use cystoscopy and ureteral catheterization at this stage, and if necessary to inject dye and obtain a pyelogram. There is no contraindication to cystoscopy in the presence of acute renal failure. It is the patient with a post-renal cause for acute failure who has the best chance of complete recovery. Once obstruction is relieved, dialysis is frequently not necessary unless rapid alteration of electrolyte in-balance is required.

The role of the urologist in the management of acute failure due to pre-renal or parenchymal dysfunction is not so clearly defined. He always participates in the diagnostic regimen, since post-renal obstruction may play a part in the management of patients with renal insufficiency. The indwelling catheter is required only if obstruction exists or an accurate account of urinary output is desired.

Chronic renal failure occurs when there is a reduction in the number of functioning nephrons. This is produced by progression of acute failure from whatever cause, due to inadequate therapy or failure of proper treatment. The importance of careful fluid balance and restricted protein intake cannot be overemphasized in the management of the patient with chronic renal insufficiency. Acidosis requires correction only when it is symptomatic. Potassium, sodium, and magnesium restriction and supplemental calcium are regulated by dietary intake. Vitamins, digitalis, antihypertensives, amphojel, and transfusions are administered when indicated. Most patients with chronic renal failure can be managed by this regimen. Only when symptomatic electrolyte in-balance can no longer be controlled by the means already stated is dialysis required.

Peritoneal dialysis is approximately 25% as efficient as hemodialysis. It is very effective in reducing edema by use of hypertonic dialysate. Its low degree of efficiency is desirable because rapid alterations in the patient's electrolytes may produce untoward effects.

Hemodialysis is the most efficient means of correcting symptomatic electrolyte in-balance. Repeated hemodialysis can be accomplished by use of an arterio-venous shunt.

Renal transplantation is in the realm of clinical experiment and is recommended only when all other means of treating renal failure have been exhausted and the outlook is hopeless.

TREATMENT OF CHRONIC UREMIA

1. Careful fluid balance
2. Low protein diet
3. Anabolic steroids

INTESTINAL LOOP DIALYSIS

ADVANTAGES	DISADVANTAGES
1. Permits home dialysis	1. Requires laparotomy
2. No anticoagulation	2. Less efficient than hemodialysis or peritoneal dialysis
3. No blood required	3. Poor for anuric patients
4. No risk of peritonitis	4. Creates psychological problem
5. Effective if creatinine clearance is above 2 ml/min	5. Problem of leakage
6. Inexpensive	6. Not indicated for acute renal failure or poisons

4. Correct symptomatic acidosis
5. Potassium and magnesium restrictions
6. 20-40 mEq sodium daily
7. Supplemental calcium
8. Amphojel
9. Transfusions with washed packed RBC
10. Digitalis, antihypertensives
11. Vitamins

The use of an isolated intestinal loop for intermittent dialysis apparently facilitates the management of patients in chronic renal failure. At Jefferson Medical College Hospital, an isolated loop of ileum was first used and then changed to a loop of jejunum, 72 to 80 inches long. Catheters are used in the proximal and distal stoma for the inflow and outflow of dialysis fluids. The dialysate is made from tap water and need not be sterile.

Dr. James Clark at Jefferson Hospital has a series of 25 patients, three of whom had an isolated loop of ileum and 22 of whom had an isolated segment of jejunum. The results in the second group have been gratifying. These patients, all in chronic renal failure, with creatinine clearance less than 6 ml per minute, were critically ill prior to the construction of the loop. Twelve patients are at home, carrying out their own dialysis with work capabilities ranging from full time work to semi-invalidism. There were no operative deaths.

A small number do require frequent hemodialysis through an arterial-venous shunt, in addition to loop dialysis. The longest follow-up is in a patient having lived 25 months. Dialysis is begun within 24 hours after surgery, using a 5% glucose solution containing 50 mEq/l of sodium chloride and 4 mEq/l of potassium chloride.

RENAL HYPERTENSION

About 5-20% of cases of hypertension are of renal origin. The most common underlying kidney disorders are unilateral chronic atrophic pyelonephritis and renovascular disease.

Detection of renal hypertension is important, since appropriate renal or renovascular surgery can cure it. The diagnosis is established by the clinical history, physical findings, intravenous and retrograde pyelography, differential renal function studies, renogram, renal arteriography, and in certain instances, renal biopsy.

The use of the Howard, Rapaport, and Stamey differential renal function studies has improved clinical evaluation of patients with renovascular hypertension. They have provided increasingly accurate prognosis in treatment.

The Howard test is based on the observation that reduced renal arterial flow to one kidney will cause that kidney to produce urine of lesser volume and lower sodium concentration than the normal contralateral kidney. Leakage around the ureteral catheters, inadequate urine volumes, and inconsistent results over several collection periods have made results equivocal in at least 15% of instances.

The Rapaport test (sodium-creatinine concentration test: tubular-rejection fraction-ratio, TRFR) is based on the principle that the defective kidney in renal hypertension retains sodium and water to a greater extent than the other. Thus the urine-to-plasma ratio of sodium (U/P_{Na}) is lower in urine of the affected kidney, and the urine-to-plasma ratio of endogenous creatinine (U/P creat) used as a measure of the proportion of filtered water absorbed by the tubules is higher. A high TRFR suggests relative arterial obstruc-

tion of the right kidney, whereas a low value implies arterial obstruction of the left kidney. False negative results have occurred with obstruction of only a branch of the renal artery and with bilateral renal artery stenosis. Also in hydronephrosis false positive results have been encountered.

The Stamey test employs the principle that renal plasma flow is reduced in the ischemic kidney. Total water reabsorption is greater in the ischemic kidney, so that an increased concentration of inulin, para-aminohippurate (PAH) or creatinine is found in the urine from such a kidney. The infusion of urea, saline, and antidiuretic hormone (ADH) amplifies the difference in total water reabsorption between the ischemic and non-ischemic kidney. Patients with main renal artery occlusion will excrete three times as much urine per unit time from the normal kidney than from the ischemic kidney. The PAH concentration in the urine from the affected kidney will be increased by 100% over that from the normal kidney. The ratio of urine flow rates from the kidney must show close agreement in the three collection periods (within 6%) for a valid study.

Increased phenosulfonphthalein concentration in urine from the ischemic kidney may also reflect increased water reabsorption by that kidney.

The intravenous urogram is an important screening procedure for renovascular disease. Rapid sequence technique (one to four minutes), double dose of contrast agents, and continuous drip urography have been recommended for better visualization of pelvio-calyceal outlines in obstructive disease, renal hypertension, and in azotemic patients with impaired renal function. The relative size of the kidneys and delayed excretion of the dye by the rapid sequence method are significant in renovascular disease. In cases of nonfunction of a kidney, retrograde pyelography is definitely indicated. If one kidney is smaller than normal, parenchymal atrophy suggests chronic pyelonephritis or renovascular disease. One must be able to differentiate congenital hypoplasia from the above by appearance of the pelvio-calyceal outline. Any deviation from the normal necessitates a retrograde study if the intravenous study is unsatisfactory.

The radioactive I^{131} renogram is an important screening procedure for renovascular stenosis. This study indicates renal blood flow. It is easy to perform, it may be repeated frequently during the same day, reactions are rare, and it is relatively inexpensive. It remains, however, a qualitative test in determining renal blood flow of each kidney simultaneously. If it is variable, differential renal function estimations are indicated.

There is no distinct value in obtaining renal biopsy unless there is some difficulty in recognizing the exact abnormality of the kidney or the possibility of bilateral arteriolar sclerosis or chronic pyelonephritis which may contraindicate corrective surgery.

The definitive diagnosis of renovascular disease depends upon renal arteriography. If any doubt should remain in cases of demonstrable renal arterial lesions as to its relationship to the hypertensive process, differential renal function studies would lend credence to a positive or negative diagnosis. The methods of renal angiography usually employed are translumbar aortography or percutaneous retrograde femoral arteriogram. This procedure is now used routinely. Frequently one finds that the other methods of diagnosis may be overlooked in preference to renal angiography. Obviously this is a great mistake. The procedure is not without some degree of complication, particularly in selective renal artery roentgenography. However, with experience and improved methods, many dangers may be averted. It should not become a routine study for renal disease unless there are definite indications for its use. Its use in the diagnosis of renal masses and differentiation between cystic and solid tumors is recognized, but it is not absolutely necessary, particularly if an exploratory operation is contemplated or before the conventional diagnostic procedures have been done.

SELECTION OF CASES FOR INVESTIGATION

1. **Young hypertensive**
2. **Sudden acceleration of pre-existing mild hypertension**
3. **Recent and abrupt onset of hypertension**
4. **Very severe hypertension**
5. **Abdominal systolic bruit over renal area**
6. **Absence of family history of hypertension**
7. **Flank pain with or without hematuria**
8. **Minimal sclerosis with pronounced constriction of retinal arterioles**
9. **Difference in size of the kidneys**
10. **Abnormal IVP**

RENAL HYPERTENSION WORK-UP

1. History and physical examination
2. IVP
   - Rapid sequence
   - Urea wash out
3. Renogram and renoscan
4. Split renal function tests
   - Howard
   - Rapaport
   - Stamey
   - PSP concentration
5. Renal arteriogram
6. Renal biopsy (Juxta-glomerular cells)
7. Pressure gradient in renal artery
8. Angiotensin assay

PATHOLOGY

1. Atherosclerosis
2. Thrombosis
3. Fibrosing lesions
   - Intimal
   - Transmural
   - Subadventitial
   - Fibromuscular
4. Stenosis of main renal artery or branches
5. External compression

SURGICAL TREATMENT

1. Nephrectomy
2. Vascular repair or replacement
   - Craft replacement
   - Endarterectomy
   - Shunt
   - Bypass graft

CONTRAINDICATION TO SURGERY

1. Marked azotemia
2. Elderly patient
3. Surgical risk too great
4. Mild hypertension or good response to drug therapy
5. Negative split renal function tests

PROSTATIC MALIGNANCY

Until recently we have had little to offer a patient with advanced disseminated prostatic cancer once their disease has escaped the effects of orchiectomy and the administration of estrogens. Some patients have benefitted from the intravenous administration of estrogens, but finally this mode of therapy also has become ineffective.

Five patients at Jefferson Hospital in the past year have undergone stereotaxic radiofrequency hypophysectomy. This has proved to be a fairly safe and innocuous procedure by which the pituitary gland is completely destroyed via a transnasal approach. A small electrode is passed through the nasal cavity and the sphenoid sinus into the pituitary gland under x-ray guidance, using a stereotaxic device. There was no operative mortality or morbidity. All the patients were up and about on the evening of operation and four of the five patients were pain-free within 24 hours after operation. The first patient had no effect from the operation and died three weeks later. The second patient survived eight months pain-free and then died of metastasis. The third patient, a 72-year-old man, is living and well at home and has been pain-free for nine months. The fourth patient has been in remission for eight months and is working as a night watchman. The fifth patient has been pain-free and well for the past two months.

Ossification of osteolitic lesions has been demonstrated radiographically in three of the five patients. Of the four patients who have achieved benefit from this procedure, two had raised acid and alkaline phosphatase levels before operation; these fell to normal after operation. The lack of serious morbidity and the absence of operative mortality have given hope that this procedure may be used routinely when patients fail to respond to conventional forms of therapy.

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300.00*	181.25	241.50	201.50	217.25	289.50	241.50	260.00	346.50	289.50	241.50
250.00	151.25	201.50	201.50	181.25	241.50	241.50	217.00	289.00	241.50	241.50
200.00	121.25	161.50	161.50	145.25	193.50	193.50	173.75	231.50	193.50	193.50
150.00	91.25	121.50	121.50	109.25	145.50	145.50	130.75	174.00	145.50	145.50
100.00	61.25	81.50	81.50	73.25	97.50	97.50	87.50	116.50	97.50	97.50
50.00	31.25	41.50	41.50	37.25	49.50	49.50	44.50	59.00	49.50	49.50

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RAYMOND C. V. ROBINSON, MD

CORTICOSTEROIDS ARE FREQUENTLY prescribed in high initial dosage and tapered to maintenance level at the discretion of the physician. The administration of fixed-ratio combinations of steroids and unrelated substances would require that the latter be given in correspondingly high doses, increasing the risk of undesirable or toxic side effects from the non-steroidal component. The use of such combinations, therefore, has been discouraged.

The risks associated with corticosteroid therapy are well known, and the side effects are often insidious. A combination of drugs which would permit reduced steroid dosage without concomitant reduction in therapeutic efficacy would offer distinct advantages. Such a synergism seems to exist between dexamethasone, a potent anti-inflammatory glucocorticoid, and cyproheptadine, an anti-histaminic with antiserotonin activity. During a two-year period (1961-1963) this combination, known as Dronactin, was studied in a variety of inflammatory and allergic dermatoses, to determine if a "steroid-sparing" synergism actually exists.

The therapeutic effects and low incidence of undesirable side effects warrant the following report.

A total of 225 patients from private practice or the out-patient department of Woman's Hospital, Baltimore, were treated. Dermatoses included dermatitis venenata, urticaria, dermatitis repens, neurodermatitis (atopic dermatitis), erythema multiforme, insect bites, seborrheic dermatitis, and exfoliative dermatitis.

The medication was supplied as white tablets, each containing 0.25 mg dexamethasone and 4.0 mg cyproheptadine hydrochloride, or a syrup containing the compounds in the same proportion so that one teaspoonful equaled one tablet.

The results of the study are summarized in the table.

Results in the treatment of *dermatitis venenata* were impressive. This condition, while self-limited, is frequently distressing to the patient because of the intense itching and unsightly vesicles and edema.

Forty-six of 52 patients were observed after three to six days of dexamethasone-cyproheptadine therapy. Results in all were good to excellent, with subjective relief in 8 to 12 hours and reduction of edema within 24 hours. Vesicles continued to form for 24 to 48 hours in a few patients but with minimal swelling or itching. Six patients failed to return for follow-up observations, although three of these cancelled their appointments by telephone because "the condition had improved so much."

Sixty patients with *neurodermatitis (atopic eczema)* were treated for five days to three months. All but five were treated for less than

A combination of dexamethasone and cyproheptadine proved safe and effective in treating a variety of dermatoses. This combination offered a significantly lower dose of systemic corticosteroid than is usually required.

This study was supported by a grant-in-aid from Merck, Sharp and Dohme.

225 Patients with Various Dermatoses, Treated with Dexamethasone-Cyproheptadine 3 to 6 Tablets Daily. Age Range was 11 to 76 Years, and Sex Distribution was Approximately Equal.

Diagnosis	Number Patients	Duration of Treatment	Therapeutic Results: Excellent	Good	Poor	Adverse Reaction	No Follow-up Observations
Dermatitis venenata	52	3-6 days	40	6			6
Neurodermatitis (Atopic dermatitis)	60	5 days to 3 months	50	4		3	3
Dermatitis repens	63	5-14 days	50	8		2	3
Erythema multiforme	15	7-15 days	8	3	3		1
Urticaria	10	5 90 days	9				1
Exfoliative dermatitis	6	1-3 weeks		1	2	3	
Insect bites	8	3-8 days	8				
Seborrheic dermatitis	11	7-15 days	2	6	1		2

two weeks with dexamethasone-cyproheptadine, since long-term systemic corticosteroid therapy is not desirable, even with small doses as contained in Dronactin.

Patient selection in this group depended on previous failure of local therapy to control the symptoms. Addition of the systemic drug was the only change in treatment, allowing critical evaluation of the results.

Three patients failed to return for follow-up observations. The remaining 54 had good to excellent results, with relief of subjective symptoms and objective improvement.

Three patients complained of excessive drowsiness and weight gain. The weight gain, which did not appear related to moisture retention or change in eating habits, was noted in other groups of patients in the study and remains unexplained.

Dermatitis repens is an infectious eczematoid eruption of the hands or feet characterized by peripherally spreading vesicles or vesico-pustules. It frequently affects housewives, beginning under the wedding band. The condition usually responds to topical therapy with antibacterial-corticosteroid combinations, such as triclobisonium-hydrocortisone or nystatin-neomycin-corticosteroid. Frequently there is sufficient edema and itching to justify a short course of systemic corticosteroid therapy. Sixty-three patients were treated with dexamethasone-cyproheptadine for five days to two weeks.

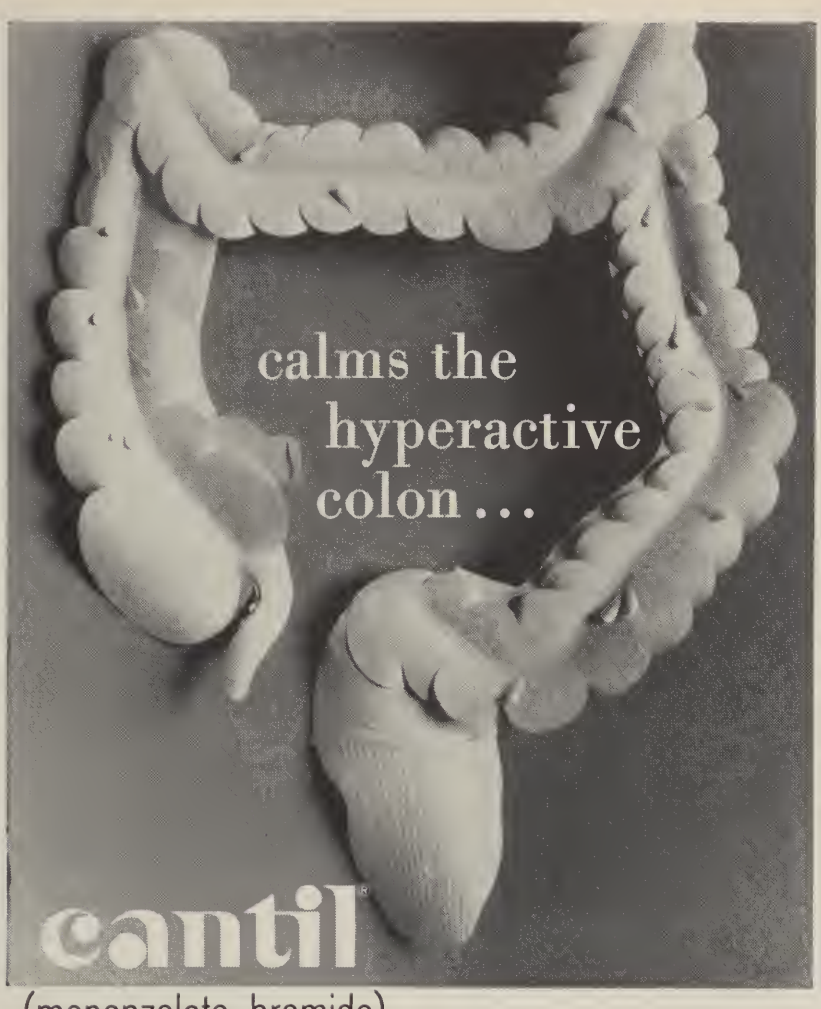
Fifty-eight patients had good to excellent results, with relief of itching and reduction in erythema and edema. Two patients noted drowsiness which was objectionable. Three patients did not return for follow-up observation.

Fifteen patients with *erythema multiforme* were treated for seven to 15 days. Three failed to show significant improvement, but 11 had good to excellent results. One was not observed after treatment was started.

Nine patients with *urticaria* had excellent results. After the first three or four days, dosage was reduced to one or two tablets daily. Four patients were maintained on one tablet daily for three months.

Results in *exfoliative dermatitis* were not encouraging, but this was to be expected since this condition usually requires a relatively high dosage of corticosteroid and this would have introduced an objectionable level of cyproheptadine hydrochloride.

Eight patients with *insect bites,* including bee stings, spider bites, and chiggers, responded well to three or four tablets daily for three to eight days.



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helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Seborrheic dermatitis improved in eight patients, but local therapy usually suffices in this condition.

DISCUSSION

In my experience, prednisone is a good yardstick by which to measure the therapeutic efficacy of newer corticosteroids. Based on results obtained with prednisone in similar conditions, it is my opinion that one Dronactin tablet is equivalent to 5 mg prednisone, which is equivalent to 0.75 mg dexamethasone. Therefore, based on clinical experience, the combination of 4.0 mg cyproheptadine hydrochloride and 0.25 mg dexamethasone is equivalent to 0.75 mg dexamethasone, suggesting an additive action. Since the study did not include other combinations of corticosteroids with antihistaminics or antipruritics, I offer no speculation as to their possible value.

Because of the diabetogenic effects of corticosteroids, 12 patients who took the drug for four to seven weeks had postprandial blood sugar determinations. All were within normal limits.

The only untoward side effects were drowsiness and an occasional significant weight gain, which was objectionable to most, although three patients were pleased with the added weight.

The effects in dermatitis venenata, neurodermatitis, urticaria, and insect bites were excellent.

1004 N. Calvert St.
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GENERIC AND TRADE NAMES OF DRUGS

Cyproheptadine hydrochloride—*Periactin*
Dexamethasone—*Decadron, Deronil, Dexameth, Gammacorten, Hexadrol*
Dexamethasone-cyproheptadine—*Dronactin*



more complete relief for the "dyspeptic"

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DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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PROJECT HEAD START

THOUSANDS OF PHYSICIANS across the country took part this past summer in the important medical aspects of Project Head Start, the War on Poverty's program for preschool children from low-income families.

In Maryland, more than 5,000 children have been registered in child development centers located in schools, churches, and community buildings in both urban and rural areas. More than 1,600 professional and volunteer workers are carrying out a massive program to help prepare these youngsters to enter local school systems this fall.

Maryland is contributing some $100,000 of the $.8 million total cost. The Office of Economic Opportunity furnishes the balance to rent facilities and to train and pay doctors, teachers, and social workers participating in Project Head Start.

Head Start represents the first major attack on the nation's poverty problem through an attempt to give preschool children of the poor a chance to catch up with their contemporaries *before* kindergarten or first grade and thus reduce the chances of a first-grader becoming drop-out material.

A three-way program directed at the "whole child" and comprising medical examinations and care, social services for him and his family, and a preschool educational program based on accepted principles was drafted by Head Start's Planning Committee, chaired by Robert E. Cooke, MD, chief of pediatrics at The Johns Hopkins University. Other physicians on the committee are: Edward Perry Crump, MD, professor of pediatrics at Meharry Medical College, Nashville; Edward Davens, MD, deputy commissioner, Maryland State Department of Health; Reginald Lourie, MD, director Department of Psychiatry, Children's Hospital, Washington, DC, and medical director of the Hillcrest Children's Center, also in Washington. Program director is Julius B. Richmond, MD, dean of the medical faculty of the State University Upstate Medical Center, Syracuse, NY.

Primary emphasis on health is due to the high incidence of physical defects customarily found in underprivileged children. About one-third of the 1,000,000 children from low-income families who will enter kindergarten or first grade are poorly prepared for school. Without special help they are destined to fall further and further behind their more fortunate classmates.

Medical statistics are expected to show that 90% have never had a physical examination; partial blindness will be found in 4% and some eye trouble in another 15%; 10% will have hearing difficulties, and as many as 50% will have no record of immunization against diphtheria or tetanus. A number of active cases of tuberculosis and many, many contacts will probably be discovered during the examinations. Finally, the examinations are expected to reveal 5% of the children with nutritional deficiencies and 2% mentally retarded.

The significance of these statistics is well known to pediatricians but not to the lay public unaware, for example, that the millions of measles cases each year can cause lung and brain damage to children living under poor conditions and suffering from a lack of proper care.

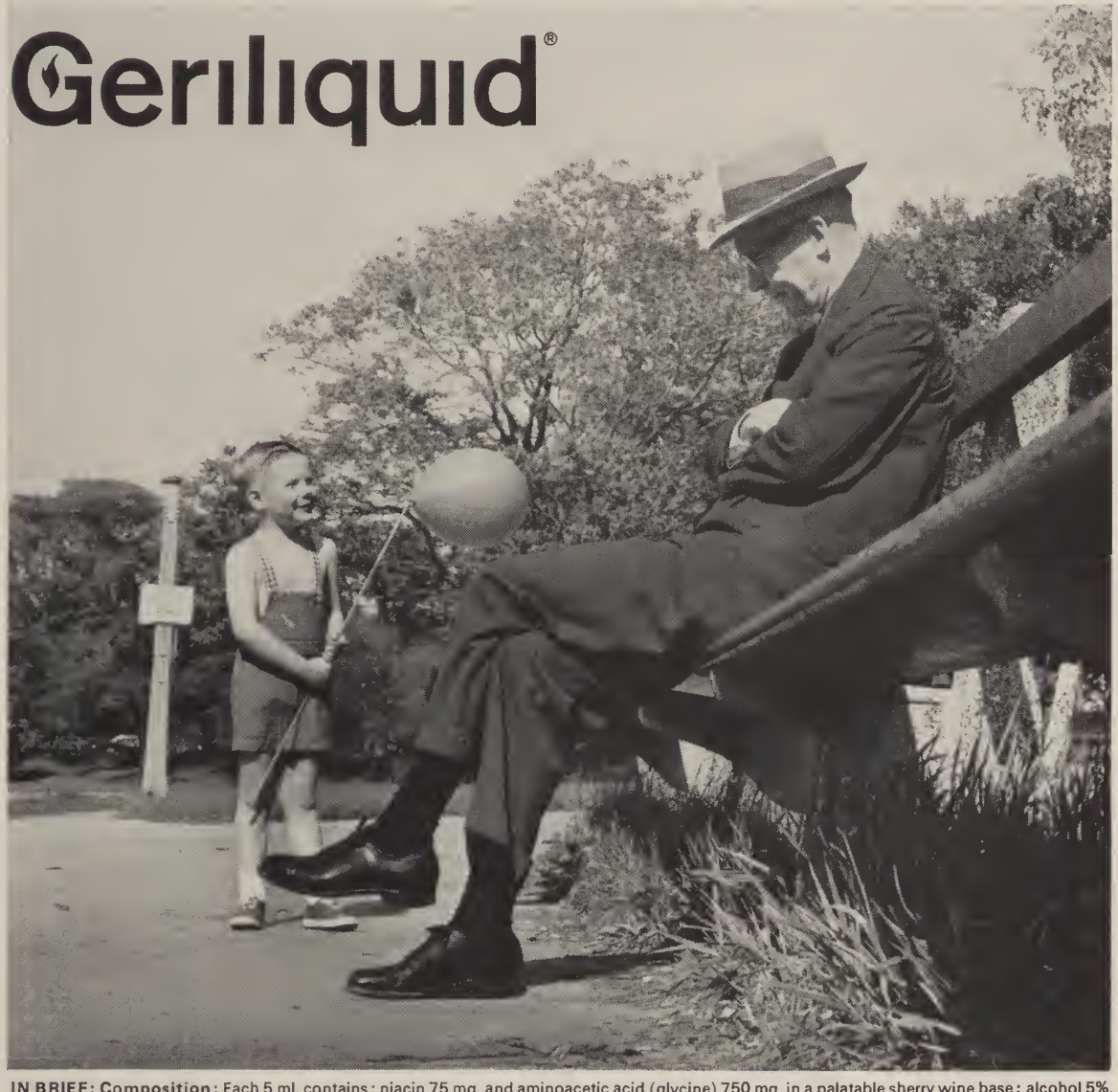
To help meet this challenge, professional associations such as the American Academy of Pediatrics, American Psychiatric Association, American Dental Association, American Nursing Association, and others have offered the services of their members. The National Society for the Prevention of Blindness is training volunteers to conduct visual screening examinations preliminary to the more thorough examinations by the doctors.

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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

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Head Start's medical examination is the first for most of the 500,000 children enrolled in the program.

"Specialists in child care have realized," said Dr. Richmond, "that the development of the child does not unfold automatically; rather it is dependent upon adequate health supervision and tender, stimulating care."

Fundamental to Head Start is the belief that the early childhood years are the most critical point in the "poverty cycle," a period when the creation of learning patterns, emotional development, and the formation of individual expectations and hopes take place at a rapid pace. For the child of poverty there are early observable deficiencies in these processes which lay the foundation for a pattern of failure—and thus a pattern of poverty—during his entire life.

Sufficient research has been accomplished to make clear that the preschool years are important in offering an opportunity to break the poverty cycle and, through the child, to gain access to the family and its problems. It is equally clear that a successful program of this kind must be interdisciplinary, involving activities generally associated with the fields of social service and education as well as health.

Recognition of this is seen clearly in a joint statement of the U.S. Commissioner of Welfare and the U.S. Commissioner of Education, issued on January 6, 1965: "Adequate care and protection of children in day care must combine the services of *health, education, and welfare*—services fundamental to the growth and development of the child."

The medical examination, important though it is, constitutes only the first phase of the medical activities of Head Start. Equally important is the referral of children to community facilities for indicated treatment and a follow-up by a public health nurse or social worker to make sure that the recommended steps have indeed been taken. In many cases, families are unaware of the existence of free health services in their community.

To assist in evaluating this broad program, the American Academy of Pediatrics, through its state chapters, is offering appraisal services. Similar cooperation is being extended by medical school faculty members throughout the country.

Each medical consultant was asked to visit several child development centers in his area, review the medical services, and suggest improvements. In certain situations, he was requested to help a center or sponsoring agency with a special problem in developing pediatric care. Corresponding appraisals by specialists in the field of preschool education will also aid in assessing the program's effectiveness. In all cases, however, remedies depend on local community action to improve or correct situations uncovered by the consultants.

Apart from the sheer size of the effort (an anticipated 100,000 registrations quickly grew to five times that number), an unusual feature is the participation of the parents in their children's activities. Parents work in the program as aides, help in program planning, and many non-professional jobs, depending on their availability and special aptitudes or interests. An important objective is to educate the parents to the need as well as the existence of local health services.

A new program, Head Start is building on a solid foundation which has existed for many years, although past school-centered programs have been available only to small numbers of children. One overriding fact underlies both the new and the old: children are children. The fundamental patterns of development and the fundamental needs are human. Within this frame, some differences exist.

The new program serves children bringing with them more than their share of hurts from the past, so that working with them in small groups has seemed especially important. Children from low-income families are also likely to have more need for comprehensive medical, psychological, and welfare services; therefore access to these resources is important.

Head Start, rising on a solid basis of knowledge and accepted doctrine, represents, in the words of the Planning Committee, "an immediate and massive intervention in the poverty cycle."

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: ACTIONS AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (Iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

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PRINCIPAL TOXIC, ALLERGIC, AND OTHER ADVERSE EFFECTS OF ANTIMICROBIAL AGENTS

All antimicrobial agents are capable of causing allergic or toxic reactions, and probably all can cause superinfections. As with most drugs, adverse effects are related to such factors as dosage, the state of kidney and liver function, and the age of the patient. There are special hazards with the premature infant and the neonate, whose detoxification mechanisms are not fully developed. In the elderly, reduced functional capacity of the kidneys may increase the toxic and other adverse effects of drugs excreted by the kidneys.

ALLERGIC REACTIONS

The penicillins and the sulfonamides are the antimicrobial agents most likely to cause allergic reactions. Anaphylactic shock and possibly delayed allergic reactions, such as drug fever, asthma, urticaria, and serum sickness, occur more frequently with parenteral than with oral administration. The cholestatic jaundice sometimes caused by triacetyloleandomycin and erythromycin estolate (Ilosone) may be a manifestation of drug sensitivity rather than a toxic reaction.

GASTROINTESTINAL SIDE EFFECTS

Gastrointestinal disturbances are quite common following antimicrobial therapy; they are usually dose-related, and may occur with any antimicrobial agent administered orally or, occasionally, parenterally. Nausea, dyspepsia, and diarrhea may be due to primary irritation of the gut by the antimicrobial drug or to superinfection by resistant staphylococci, fungi (especially *Candida albicans*) or other organisms. Superinfections in the alimentary tract and in other organs may occur during oral or parenteral treatment with many antibiotics, but they are especially frequent with oral administration of broad-spectrum drugs such as the tetracyclines. Anal itching is a frequent side effect of orally administered antibiotics and has been attributed to superinfection by fungi; oral or topical administration of a fungistatic agent such as nystatin or amphotericin B is sometimes effective in relieving the symptom. A rare adverse effect of antimicrobial therapy is an intestinal malabsorption syndrome, occurring chiefly with neomycin and kanamycin.

ANTIMICROBIALS IN RENAL INSUFFICIENCY

Most antimicrobial agents and their metabolites are excreted mainly in the urine. A few (erythromycin, novobiocin, and triacetyloleandomycin) are excreted largely by way of the biliary tract. The usual doses of most antibiotics can be given with reasonable safety to most patients during the first 24 hours of therapy, but in patients with renal insufficiency, subsequent doses should be reduced to avoid the risks of toxic drug concentrations in blood and tissues. Even the initial doses of antimicrobials with high renal or auditory-nerve toxicity, such as streptomycin, kanamycin, neomycin, polymyxin B and polymyxin E (colistimethate), should be reduced in patients who have impairment of renal function. Maintenance doses of all agents should be reduced if the patient is dehydrated or renal function is impaired. Where laboratory facilities are available, chemical analysis of antibiotic blood levels or bioassay of serum antimicrobial potency is helpful in defining dosage requirements and minimizing toxicity.

USE IN PREGNANT WOMEN AND IN THE NEWBORN

The sulfonamides, chloramphenicol, the tetracyclines, streptomycin, novobiocin, erythromycin, and nitrofurantoin have been suspected of causing injury to the fetus or the newborn when administered during pregnancy or lactation. Though the evidence is questionable, all antimicrobial agents should be administered cautiously to pregnant women, nursing mothers, and premature and newborn infants. There is no convincing evidence that administration of any antimicrobial drug to pregnant women has had teratogenic effects. Chloramphenicol and the sulfonamides are metabolized and detoxified with the aid of liver enzymes which may not be active in newborn infants; if possible, their use in the newborn should be avoided.

Reprinted from *The Medical Letter* 7:18 (Aug. 27) 1965.

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
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THE TABLE

The principal adverse effects of the common antimicrobial agents are given in the following table. With many drugs, it has been difficult to estimate the frequency of adverse effects on the basis of published reports. The frequencies indicated are based on the judgment of *Medical Letter* consultants as well as on published reports; doubtless, continuing experience will dictate changes in the estimates of frequency. In general, toxic and other adverse effects are more severe with parenteral than with oral administration. Gastrointestinal disturbances are much more frequent with oral than parenteral administration and may occur with any antimicrobial agent; they are omitted in the table when they appear to occur only rarely.

p-AMINOSALICYLIC ACID

Frequent: GI disturbances, allergic reactions often with fever
Occasional: blood dyscrasias
Rare: severe liver damage

AMPHOTERICIN B

Frequent: renal damage, anemia
Occasional: fever, hypotension, liver damage, blood dyscrasias

BACITRACIN

Frequent: renal damage (P)
Occasional: blood dyscrasias (P)

CEPHALOTHIN*

Frequent: allergic reactions; pain at site of injection
Rare: neutropenia (possibly allergic)

CHLORAMPHENICOL

Occasional: blood dyscrasias, usually severe and sometimes fatal
Rare: allergic reactions, peripheral neuropathy, optic atrophy
(Chloramphenicol is detoxified by the liver; use with extreme caution in newborn and patients with liver disease.)

COLISTIMETHATE (POLYMYXIN E)

see POLYMYXIN B

CYCLOSERINE

Frequent: confusion, drowsiness, coma
Occasional: peripheral neuropathy
Rare: seizures, psychosis

ERYTHROMYCIN

Occasional: GI disturbances
(Erythromycin estolate may occasionally cause cholestatic jaundice, possibly allergic.)

ETHIONAMIDE*

Occasional: GI disturbances, liver damage, peripheral neuropathy, allergic reactions

GRISEOFULVIN

Occasional: GI disturbances
Rare: allergic and photosensitivity reactions, renal damage, blood dyscrasias, lupus-like syndrome

ISONICOTINIC ACID HYDRAZIDE

Occasional: peripheral neuropathy
Rare: allergic reactions, liver damage, blood dyscrasias, psychosis

KANAMYCIN and NEOMYCIN

Frequent: auditory-nerve damage (P)
Occasional: renal damage, usually reversible (P)
Rare: peripheral neuropathy (P), blood dyscrasias (P), intestinal malabsorption, allergic reactions
(Intraperitoneal administration may cause respiratory depression and arrest; topical application occasionally causes contact dermatitis and conjunctivitis.)

LINCOMYCIN*

Frequent: diarrhea on oral administration

METHENAMINE MANDELATE

Rare: allergic reactions, crystalluria with renal damage

NALIDIXIC ACID*

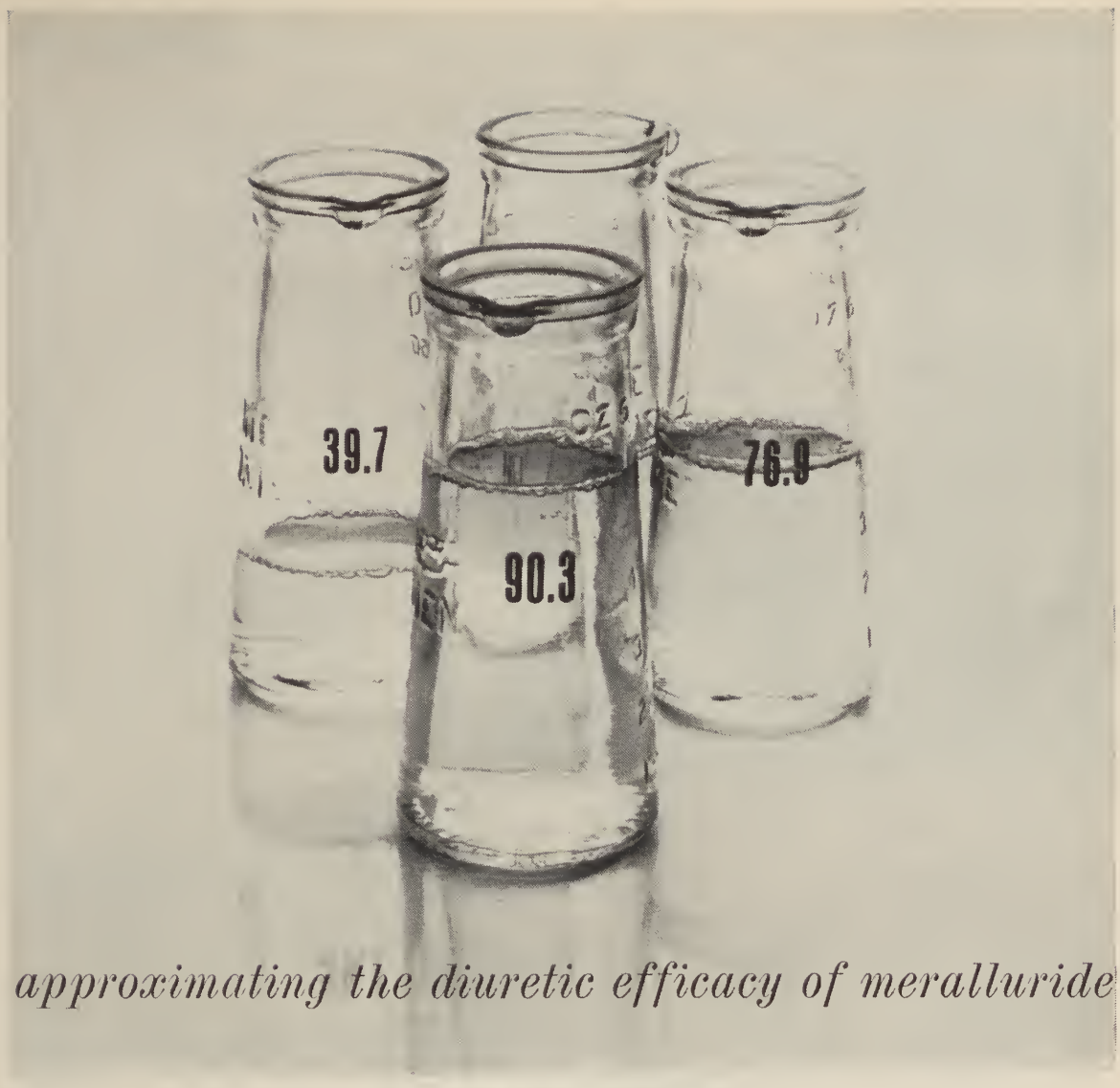
Occasional: GI disturbances
Rare: photosensitivity reactions, seizures

NEOMYCIN, see KANAMYCIN

NITROFURANTOIN

Occasional: allergic reactions, GI disturbances

(P) Adverse effects which occur only with parenteral administration, but not with oral or topical use of the drug.
*New agent; experience is insufficient for adequate evaluation of the frequency, severity or range of side effects.



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(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

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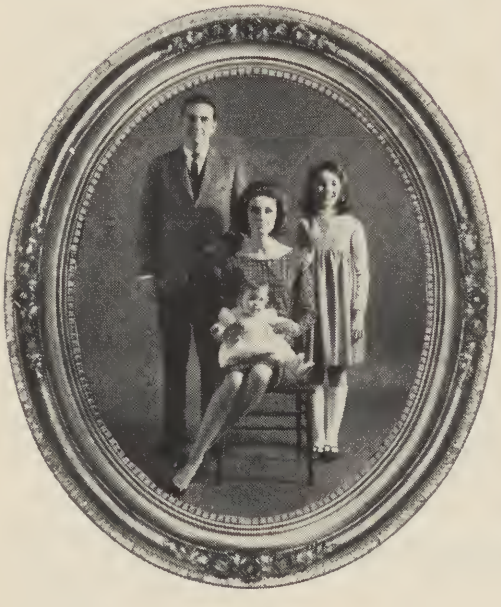
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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OF AUTOPSIES

This editorial, written by Dr. Lester S. King, former professor of pathology at Illinois, is an important backdrop to the provocative symposium on the autopsy, published in *JAMA*, September 6, 1965. *M. J. R.*

IN THESE DAYS of unbounded optimism, when medical science promises to transcend every boundary and solve all problems, the autopsy frequently becomes a matter for discussion. Numerous letters to medical journals and the lay press emphasize the need for more autopsies and for greater lay education concerning their importance. The standard arguments are that autopsies help to solve the mysteries of disease; that they inform the medical practitioner about his diagnostic accuracy, and bring home to him his mistakes; that they improve the validity of medical statistics.

Unfortunately, the problems involved are not at all simple. We cannot make the unequivocal statement, "Autopsies are good, we must have more of them, and the more autopsies we have the better is our level of medicine." A more searching analysis is desirable.

What is an autopsy? "The dissection of a dead body to determine the nature of disease," is actually a secondary meaning. The primary meaning is, "self-seeing," or "seeing for oneself," ie, direct first-hand observation, contrasting with what someone else has recorded or declared. It represents the opposite of "hearsay" evidence. The "autoptic" investigator demands personal first-hand knowledge. The autopsy constitutes, in a sense, not so much an activity as a state of mind or attitude: "Let me see," or "Show me." It indicates two important attributes, curiosity on the one hand and on the other a demand for empirical demonstration, personally observed.

The autoptic frame of mind characterizes the progressive physician who wants to find out things for himself. Until relatively recently, the only way he could do this was through anatomical dissection. Dissection might advance his knowledge of normal structure; it also would broaden his knowledge of disease. By postmortem dissection and the study of "morbid anatomy" the physician could note the hidden factors in disease and correlate these with clinical or environmental findings. In the latter 18th century, the great Morgagni, through detailed autopsies, gave us magnificent correlations between clinical features of disease and the pathological postmortem findings. The term "autopsy" became more or less restricted to postmortem dissection to determine the cause of death and to extend our knowledge of disease.

By the 19th century, although the microscope had vastly enlarged the limits of knowledge gained from dissection, other sciences gradually assumed increasing importance. Chemistry and microbiology, with their daughter sciences, contributed more and more to the understanding of disease. Today there are techniques for investigating disease that surpass the wildest fantasies of the 18th century physicians, who were restricted to relatively simple observation.

The autopsy (ie, the postmortem dissection) still constitutes one stage in the accumulation of knowledge—by which we mean the correlation of certain facts with certain other facts and the exhibition of general relationships between them. To take a single example such as "Bright's disease," our knowledge ordinarily passes through many stages, from making clinical observations, correlating these data with the findings at autopsy, expansion of knowledge through other techniques

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such as light microscopy, blood chemistry, and bacteriology, and further expansion with the most modern refinements in numerous disciplines. In a sense, all of these represent the *extension* of the autopsy. Today the morbid anatomist, who performs the dissections, becomes relatively less important. He can sometimes introduce ideas and "start the ball rolling"; in many instances, he may himself provide some specialized data—but he is really only one of a scientific community whose efforts intermingle.

It is a pernicious misconception that the mere performance of postmortem dissection leads to progress in medical science, or the discovery of new diseases, or the advancement of medical frontiers. We lose sight of the fact that progress depends not on the autopsy but on the person who is examining the material. Those who believe that the more autopsies we perform, the more medical science will advance, are actually pleading not for more autopsies but for more persons who can profitably utilize the data of autopsies, persons who have imagination, originality, persistence, mental acuity, sound education and background, the indispensable "prepared mind" without which observations are quite sterile. It is a grave disservice to confuse the performance of autopsies with the spark of insight which the autopsy may trigger. We want the insight; and autopsies alone, no matter how numerous, are not the equivalent. We must not confuse the performance of postmortem dissection with the autoptic attitude. They are utterly distinct. They may indeed coincide, but they need not.

Hospitals, for accreditation, must have a minimum autopsy rate. And many persons consider a high autopsy rate to be a sign of a good hospital. While it is in general true that the "good" hospitals have a high autopsy rate, the converse is by no means true. You cannot establish excellence by legislation. If a hospital this year has a 15% autopsy rate, and next year, through decree, has a 100% rate, what will have been accomplished? I am reminded of the little 4-year-old girl who wanted a pair of spectacles. Why? When grandma read a story, grandma put on spectacles. The child inferred that the spectacles permitted grandma to read. This, we must admit, is true. But alas, it is not *merely* the spectacles which allowed grandma to read. In the case of hospitals, it is not merely the autopsy rate which confers merit. The important aspects, the thought, care, and insight, come into being only through a long chain of educational activity.

The autopsy all too often becomes merely a nominal function. The regulatory bodies do not regulate who should attend autopsies. Practicing pathologists groan and complain about the poor attendance. It is easy to ridicule the physician who has little interest in seeing the autopsy, but we should be cautious in assessing blame. How many busy practitioners can really spare one or two hours to watch a postmortem examination, done perhaps by an inept resident? How much value would they receive for the time spent? The pathologist will often justly resent the indifference of the clinician, but the honest pathologist who has any talent for soul-searching may admit that, were he himself a clinician, he might do likewise. The pathologist can reflect, how important in his own scheme of things are the autopsies? Are they regarded as a chore? In training centers, how much time do the heads of departments spend in the autopsy room? How much time do residents spend? Under how much supervision? What is the relative emphasis on autopsies, as contrasted with "research"?

The plea for more autopsies comes from a wide range of persons who feel that there is something wrong with medicine and who want to do something about it. They feel that more and more autopsies might be the answer. I consider this to be a mistaken belief, and while granting their premises that much should be done, deny the conclusion that an increased autopsy rate is the answer.

"Let's have more autopsies" is an attempt to find an easy way out. The cry is valuable insofar as it represents a cry of distress, and the awareness that a great deal is wrong. Yet we might well be a little more clear in our own minds just what is wrong. We cannot by fiat provide increased conscientiousness, ability, or imagination. We seek more doctors who possess devotion to learning and to the advancement of medicine, who have ability for self-criticism and capacity to learn from their mistakes. We need greater education of the public in the matter of health, so that the layman can have some comprehension of medical concepts. This requires education, time, and effort. For this writer an insufficiency of autopsies is not the major difficulty, nor is it one whose correction would automatically raise the level of medicine. *L. S. K.*

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DOUGLAS G. CARROLL M.D.
EDITOR

SURGERY IN THE TREATMENT OF RHEUMATOID ARTHRITIS

LEE H. RILEY JR., MD

Assistant Professor in Orthopedic Surgery
Johns Hopkins University School of Medicine

Successful treatment of a patient suffering with rheumatoid arthritis demands the close cooperation of the rheumatologist and the orthopedic surgeon. No single treatment will result in a predictable cure of the generalized process termed rheumatoid arthritis. Our efforts, therefore, whether medical or surgical, are usually directed against the complications of the disease. They consist of prevention of deformities, relief of pain, and preservation of optimum functional capacity. Each complication of rheumatoid arthritis is primarily the result of proliferation of the synovial tissue lining of joint cavities, bursae, or tendons. This locally aggressive tissue invades and destroys articular cartilage, bone, tendon, and joint capsules, resulting in the clinical picture we associate with rheumatoid arthritis.

The duration, severity, and distribution of rheumatoid synovitis in a given patient cannot be predicted. What can be predicted, however, is that uncontrolled synovitis within a joint will eventually destroy that joint. There are, therefore, three basic aims of treatment. These are: 1. Controlling the proliferating rheumatoid synovial tissue. 2. Preventing complications secondary to its presence, such as flexion contractures and muscle weakness. 3. Reconstruction of joints destroyed by the rheumatoid process.

The orthopedic surgeon may contribute to each phase of treatment.

Control of rheumatoid synovitis before irreversible joint destruction occurs cannot always be accomplished. Often, however, it can be accomplished by intensive non-surgical treatment combining rest, appropriate medication, and physiotherapy. When such a program is not effective, a surgical synovectomy, in which the diseased tissue is removed, usually will permanently control the rheumatoid process within the joint without sacrificing the motion or stability of the joint.[1] Total synovectomy has been most effective in the control of synovitis within the knee, the wrist, the metacarpophalangeal joints, and involving the flexor and extensor tendons of the wrist and hand.

While the generalized process in the individual cannot be cured by surgery, it is possible to cure rheumatoid arthritis in those joints in which total synovectomy is technically feasible. The experiences of Savill[2] in Scotland and Laine and Vanio[3] in Finland have shown that rheumatoid synovitis can be expected not to recur in those joints in which a total synovectomy has been done. At the Johns Hopkins Hospital, we have found that after complete synovectomy the relief of pain is strik-



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ing, motion of the joints is not appreciably affected, and, if done before cartilage destruction occurs, later degenerative changes are prevented.

The second broad objective of the orthopedic surgeon is prevention of complications secondary to acute synovitis but not necessarily the result of actual joint destruction while proper medical therapy is being instituted. The two most obvious complications are flexion contractures of the knee and of the hip. The most comfortable position for the hip or the knee when acute synovitis of the joint is present is in slight flexion. If synovitis persists and this position is maintained even for a short period of time, inability to fully extend the knee or the hip will result.

Once a flexion contracture of the knee or the hip is established, a normal gait is impossible. In addition, a joint which is already damaged due to the presence of proliferating synovial tissue is forced to function in an abnormal position. This increases the possibility that actual mechanical damage will develop within the joint.

Flexion contractures of the hip and knee are much easier to prevent than to correct. The most important measure to prevent flexion contractures of the hip is to insist that the patient lie on his abdomen with hips fully extended for a short period each day. This also aids in early diagnosis of this condition, for such a posture is difficult in the presence of a flexion contracture of the hip.

Flexion contractures of the knee can be readily corrected if, when first noted, a molded posterior plaster splint extending from the groin to the toes is constructed, to be worn by the patient at night. Such a splint will usually prevent the further development of a flexion contracture. When the flexion contracture is severe, a long leg plaster cast is applied and changed several times a week, gradually correcting the deformity. This technique is time consuming for both the physician and the patient, but it is effective and not unpleasant for the patient. Surgery is seldom if ever necessary to correct flexion contracture of the knee resulting from rheumatoid synovitis within the joint and not accompanied by actual cartilage or bony change within the joint.

Physical therapy directed at maintaining muscle strength and active motion of involved joints is tremendously important. "Physical therapy," however, is in many instances a nebulous term when applied to treatment of rheumatoid arthritis. The actual objectives and limitations of physical therapy in rheumatoid arthritis need to be redefined in the light of recent advances in our understanding of the pathology and physiology of the disease.

The orthopedic surgeon may surgically modify joints which have been partially or totally destroyed. Several excellent texts have been published recently that describe the many surgical procedures available.[4,5] In general, such procedures fall into one of three categories: 1) arthroplasty, in which reconstruction of a joint is performed; 2) arthrodesis, in which a joint is fused; and 3) osteotomy, in which undesirable alignment of a joint is corrected. These procedures are employed to relieve pain, correct deformity, and improve function.

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function are routinely expected. Recent experience has shown that active rheumatoid arthritis is not a contra-indication to surgery and, indeed, it has been suggested that the generalized active disease may be improved after surgical removal of diseased synovial tissue.[3]

The successful management of the patient with rheumatoid arthritis demands constant attention to many facets of the disease over a long period of time. The surgeon has not been and should not be entrusted with the overall long term management of the patient; rather, he should function as a consulting partner, contributing his special knowledge to the solution of individual problems as they arise. For the surgeon to be content with surgically eradicating the disease in such admittedly important areas as the knee, wrist, and hand while ignoring the many manifestations of disease elsewhere would be folly. Likewise, to restrict treatment to the systemic aspect of the disease and to ignore surgical treatment of specific problems is equally unwise. The surgeon will, at best, cure the disease process within a given joint. He may prevent some complications such as flexion contractures, while proper medical therapy is being instituted, and may reconstruct joints previously destroyed. Surgery properly conceived, properly timed, and skillfully executed can be a powerful weapon in the battle against rheumatoid arthritis.

REFERENCES

1. Aidem, H. P., and Baker, L. D.: Synovectomy of the Knee Joint in Rheumatoid Arthritis, *IAMA* 187:4, 1964.
2. Savill, D.: Personal communication.
3. Laine, V. and Vaino, K.: Orthopaedic Surgery in Rheumatoid Arthritis, *Bull Rheum Dis* 15:360, 1964.
4. Milch, R. A.: *Surgery of Arthritis,* Williams and Wilkins, Baltimore, 1964.
5. Flatt, A. E.: *The Care of the Rheumatoid Hand,* C. V. Mosby Co., St. Louis, 1963.

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*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

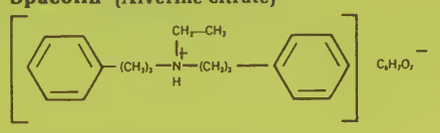


SPACOLIN™ *(Alverine citrate)*

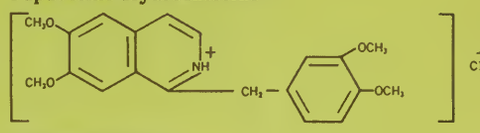
- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi.*
- Mild local anesthetic effect and decreases gastric acidity.

The chemical structures of Spacolin, Papaverine and Atropine are as follows:

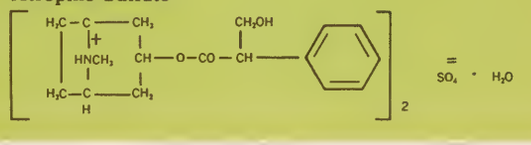
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Papaverine Hydrochloride



Atropine Sulfate



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(Alverine citrate)

the potent musculotropic counter-spasmodic 2½-3 times stronger than papaverine

IN LABORATORY

Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5°C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1/150 that of atropine sulfate.







IN MAN

Double-Blind Study of a Spasmolytic Compound[1]

By ITALO EVANGELISTA, M.D.

Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts; Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

***Excellent** — complete relief of symptoms during therapy.
Good — definite relief but still aware of symptoms periodically.
Fair — symptoms reduced in intensity but still present.
Poor — little or no therapeutic benefit.

". . . a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

(1) To be published



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INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examina-

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets 1/2 hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle de-

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The Heart Page

Ralph Weber, MD—*Editor*

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JUGULAR VENOUS PULSATIONS

RALPH WEBER, MD

Inspection of the jugular venous pulsations (JVP) at the bedside is a convenient method of studying the timing and mechanical integrity of both systolic and diastolic events of the cardiac cycle. The variations in volume of the jugular veins account for their pulsations and reflect right atrial events during the cardiac cycle, provided that venous return is not disturbed by extracardiac conditions (such as tumors, aneurysms, scar tissue, etc). Factors which influence the form of the JVP are the degree of right atrial filling and emptying (which are determined by the elastic characteristics of its walls as well as the pressure and volume of its contained blood).

In the supine position, venous pulsations are normally visible at the root of the neck. The head and neck of the patient should be elevated to whatever position reveals maximum oscillation of the JVP. In most healthy subjects this will be between 30° and 60° with the horizontal and not visible when the patient is sitting or standing. If the central venous pressure is increased, elevation of the neck to 90° with the horizontal may be required before the venous column oscillation is discernible.

Examination is best conducted from the patient's right since the jugular veins on the left are somewhat farther away from the right atrium. Generally, the JVP is slightly more prominent on the right, perhaps because the right innominate vein is shorter than the left and pursues a straight course, whereas the left innominate vein departs from the superior vena cava at a right angle.

Occasionally the left jugular veins are prominent when the right jugular veins are not, due to aortic systolic compression of the left innominate venous trunk (sign of Gonzales-Sabathié) when elongation and dilatation of the aortic arch is present. In the appropriate position, the undulating movement of a column of blood within the external jugular vein is noted as the vein courses from the angle of the jaw across the lateral portion of the sternocleidomastoid muscle and disappears in the lower portion of the posterior triangle of the neck (where it empties into the right subclavian vein beneath the clavicle a short distance from the right innominate vein). The pulsations of the more deeply situated internal jugular vein are not directly visible because of the overlying sternocleidomastoid muscle and adipose tissue (but observation of the movement of these overlying soft tissues gives similar information as the external jugular vein). In a general way, differences in intravascular pressures may best explain the clinical distinctions between arterial and venous neck pulsations. The arterial vessels comprise a relatively high pressure system (pressure pulse), whereas the veins are a relatively low pressure system (volume pulse). The table on the next page distinguishes the venous pulsations in the neck when sinus rhythm is present:

The events of the JVP in a single cardiac cycle normally comprise two positive waves (crests) and two negative waves (troughs). Both crests occur in diastole, and the time between crests is the systolic portion of the cardiac cycle, so that the normal JVP is characterized by "systolic collapse." The first crest is designated as the *a* wave and is due to the effects of right atrial systole. As the right auricle contracts, its direct communication with the veins emptying into it is sharply diminished by muscular contraction about the orifices of the venae cavae; venous engorgement ensues with an associated expansile "pre-

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	ARTERIAL	VENOUS
GENERAL CHARACTER	Sharp	Soft, undulant
	Localized	Diffuse
	Lifts palpating finger	Not palpable
	Systolic distention	Systolic collapse
	One peak	More than one peak
VARIATION		
Respiratory	No change	Passive to intrathoracic pressure (moves cephalad in expiration and caudad in inspiration)
Positional	No change	Moves cephalad as patient's position approaches horizontal & caudad as position approaches vertical
Abdominal pressure	No change	Displaces pulse cephalad
Local pressure	Pulsations and vessel unaltered by moderate finger compression above clavicle	Pulsations cease & vessel more prominent with moderate finger compression above clavicle

systolic" pulsation which immediately precedes the cardiac apical impulse and the first heart sound by a fraction of a second. The *a* wave is usually the crest of greatest amplitude in the JVP and is somewhat more abrupt than the second crest.

Immediately after the peak of the *a* wave, the first trough of the JVP occurs. This is designated as the *x* descent. The *x* descent is associated with relaxation of the right auricle, widening of the orifices of the venae cavae, and free communication of the neck veins with the right auricle and its attendant "systolic collapse." Other factors thought to favor free flow between the neck veins and the right auricular cistern at this time are the sudden drop in intrathoracic pressure (accompanying systolic ventricular ejection of blood from the chest cavity) and pulling down of the auriculoventricular border toward the apex (so called descent of the base) with right ventricular ejection. The resultant *x* descent is the deepest negative point of a normal venous pulse and coincides roughly with elevation of the pulse in the radial artery.

A positive wave, known as the *c* wave, is commonly described in textbooks (based on graphic recordings or phlebograms). This arises from carotid arterial pulsation transmitted to the recording apparatus in an early portion of the *x* descent. A small part of the *c* wave may be due to the isometrically contracting right ventricle pushing back against the closed tricuspid valve. It is not seen in bedside observation of the JVP.

The second crest of the JVP occurs at the end of systole and is known as the *v* wave. Its occurrence is gradual and undulating since it is due to gradual filling of the observed neck veins emptying with a diminished rate into the cavity of the right auricle (in which forward flow is obstructed behind the closed tricuspid valve during ventricular systole).

The second trough, designated as the *y* descent, promptly follows the *v* wave and occurs as soon as the tricuspid valve opens. The *y* descent reflects the rush of blood between the slightly raised right auricular pressure and the rapidly falling right ventricular pressure beneath the newly opened tricuspid valve. It follows the second heart sound by a fraction of a second, and the time between the second heart sound and the *y* descent is a measure of isometric relaxation. The *y* trough in the normal JVP is not well delineated during tachycardia since, with encroachment upon diastolic filling, the magnitude of *y* descent diminishes at rates greater than 100-110. When the rate approximates 150, the *a* crest and the *v* crest are almost superimposed upon each other.

An abnormally prominent *a* wave is seen as a



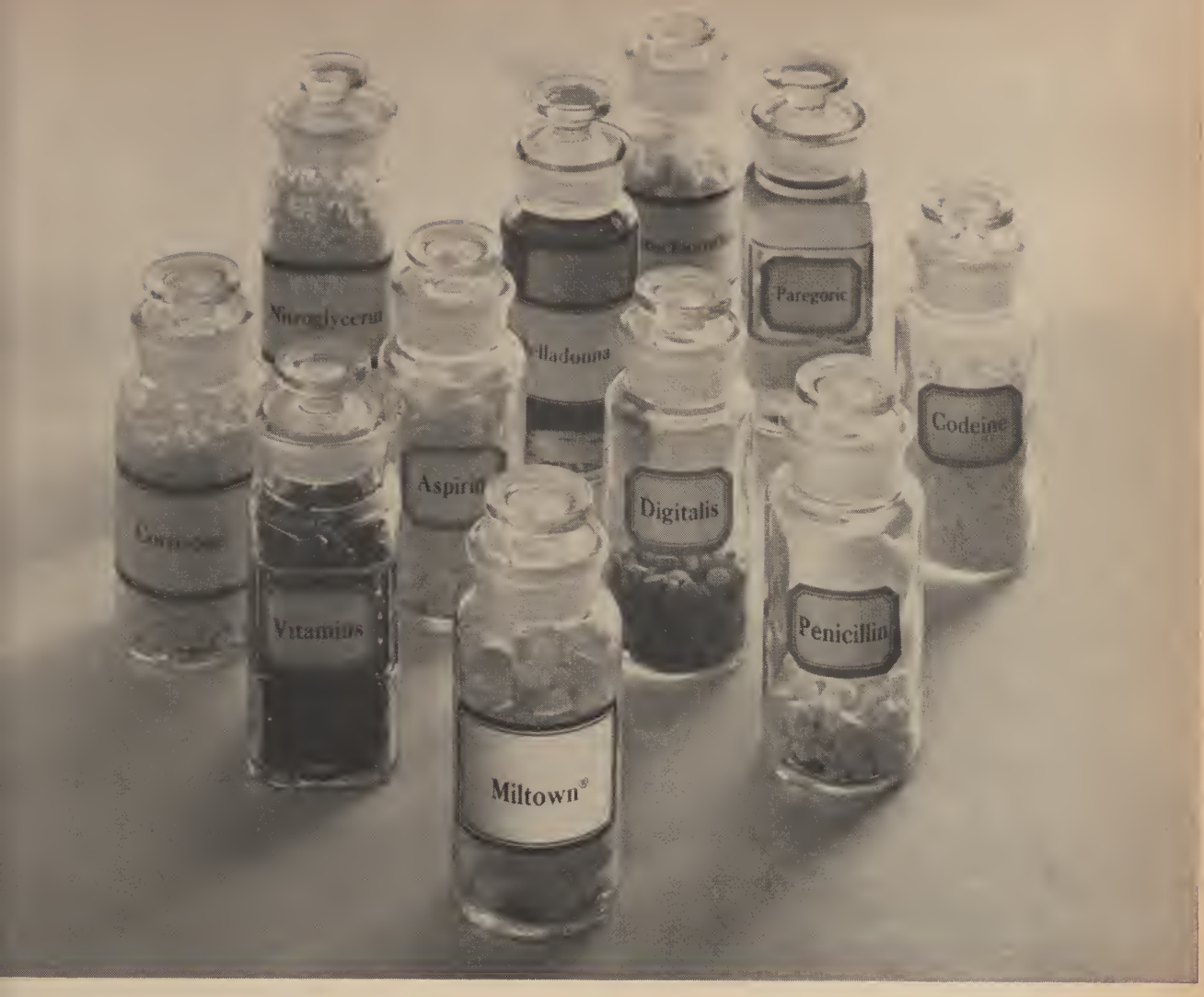
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flick due to sudden and excessive crest followed by a sharp fall. It is caused by powerful atrial contraction against increased resistance to right ventricular filling. In relation to the course of blood flow (proximal to distal) with normal rhythm, it may be anticipated in a variety of conditions in which right auricular emptying is impeded, such as right atrial myxoma, tricuspid atresia, tricuspid stenosis, severe pulmonary stenosis with intact ventricular septum, and pulmonary hypertension.

So called cannon waves are giant *a* waves which occur during arrhythmias whenever the right auricle contracts against a closed tricuspid valve. If they occur regularly, the presence of nodal rhythm or partial heart block can be suspected. If irregular cannon waves are seen, the presence of sporadic ectopic beats or complete heart block should be entertained. No *a* waves occur during atrial fibrillation, since orderly auricular contraction is completely replaced by mechanically ineffectual undulations.

Prominent *v* waves are regularly seen as a surge in tricuspid regurgitation in which blood is thrown back from the contracting right ventricle into the right auricle and reflected into the neck veins. As tricuspid regurgitation becomes more advanced, the entire length of the cervical veins may reveal systolic pulsations (Lancisi's sign) with transmission to the ear lobes. In this circumstance, the *x* descent may be almost replaced, and the positive systolic timing can cause confusion with the carotid pulse. This error can be avoided by simultaneous palpation of radial pulse (usually too small to account for a marked neck pulsation in the absence of carotid aneurysm or peripheral occlusive disease) and liver (usually pulsatile with tricuspid regurgitation) and consideration of positional changes of the JVP (see table). A prominent *y* descent might be anticipated in any condition in which the venous pressure is high and the unobstructed tricuspid valve allows blood to pour freely into the relaxing right ventricle. Indeed, a deep *y* descent is seen in constrictive pericardium and severe right ventricular failure of any cause.

In summary, the jugular venous pulsations are discernible in most adults. The physiologic events that are important in the determination of the form of JVP are reasonably well understood. Analysis of the JVP is a useful bedside technique.



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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Ground Broken for North Charles General Hospital Expansion

Groundbreaking ceremonies for a $750,000 expansion program were held recently at North Charles General Hospital, Charles and 28th streets. The new building, adjoining the existing hospital and to be completed by mid-1966, will increase total bed capacity from 85 to 150. It will contain private and semiprivate rooms, to meet the demands of the staff of 210 members. The new facilities will also include a new x-ray unit and equipment and an educational suite containing a lecture room seating 125 persons, a medical library, and offices for the staff secretary and the Director of Medical Education. Alterations to the present building will include a new pediatric unit, an intensive care unit, and a new cystoscopic room.

The ceremonies were presided over by Mr. James M. Swartz, president of the hospital board of trustees. Mr. Swartz also announced that the hospital's out-patient department is being completely renovated and special clinics are being organized under the direction of Daniel Wilfson, MD, chief of the Department of General Practice. A new cardiology clinic, directed by Harold H. Bix, MD, opened October 1 in the outpatient department, 2722 N. Charles St., adjoining the hospital.

In his remarks at the groundbreaking ceremony, Mr. Swartz praised others who have been prominent in the development of the hospital since its establishment, naming particularly Mr. Max Sokol, his predecessor, and William Schuman, MD, who organized the medical staff which led to accreditation in 1955. North Charles General Hospital was the first community hospital in the state to create a Department of General Practice (1948) and a Department of Medical Education (1955).

In 1952 the Postgraduate Institute of the hospital was founded by Dr. Schuman and is still directed by him. Among the Postgraduate Institute's recent programs have been review courses for foreign medical graduates to prepare them for the ECFMG and State Board examinations. These courses have been attended by physicians from all over the state.

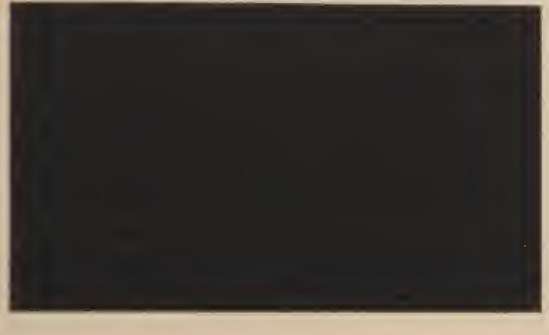


Members of the medical staff of the North Charles General Hospital active in the rebuilding program of the hospital. Left to right: A. Lewis Kolodny, MD, chairman of the Medical Executive Committee; Allan H. Macht, MD, president of the medical staff; Lester H. Caplan, MD, chief of pediatrics; David D. Golub, MD, associate in radiology; Harold H. Bix, MD, head of Division of Cardiology; and William Schuman, MD, director of medical education.

Department chiefs at the North Charles General Hospital are: Anesthesiology, Frank U. Lee, MD; General Practice, Daniel Wilfson, MD; Gynecology, Malcolm F. Freed, MD; Medicine, Abraham A. Silver, MD; Pathology, Paul F. Guerin, MD; Pediatrics, Lester H. Caplan, MD; Radiology, William Peterson, MD; Surgery, James E. T. Hopkins, MD.

President of the staff is Allan H. Macht, MD, and chairman of the Medical Executive Committee is A. Lewis Kolodny, MD. The Executive Committee contains, besides the department chiefs, four representatives from the staff-at-large, among whom must be two general practitioners.

Members of the board of trustees, in addition to Mr. Swartz, are Erwin C. Bien, Harley P. Brinsfield, B. Herbert Brown, Maurice P. Freedlander, Victor Frenkil, Irving Glasser, Chester Jennings, Jr., George S. Goodhues, S. Raymond Machen (honorary), Robert S. Maslin, Jr., Morton T. Sarubin, James W. Stevens, Milton D. Swartz (honorary), K. Herbert Turk, and Herman L. Winston.



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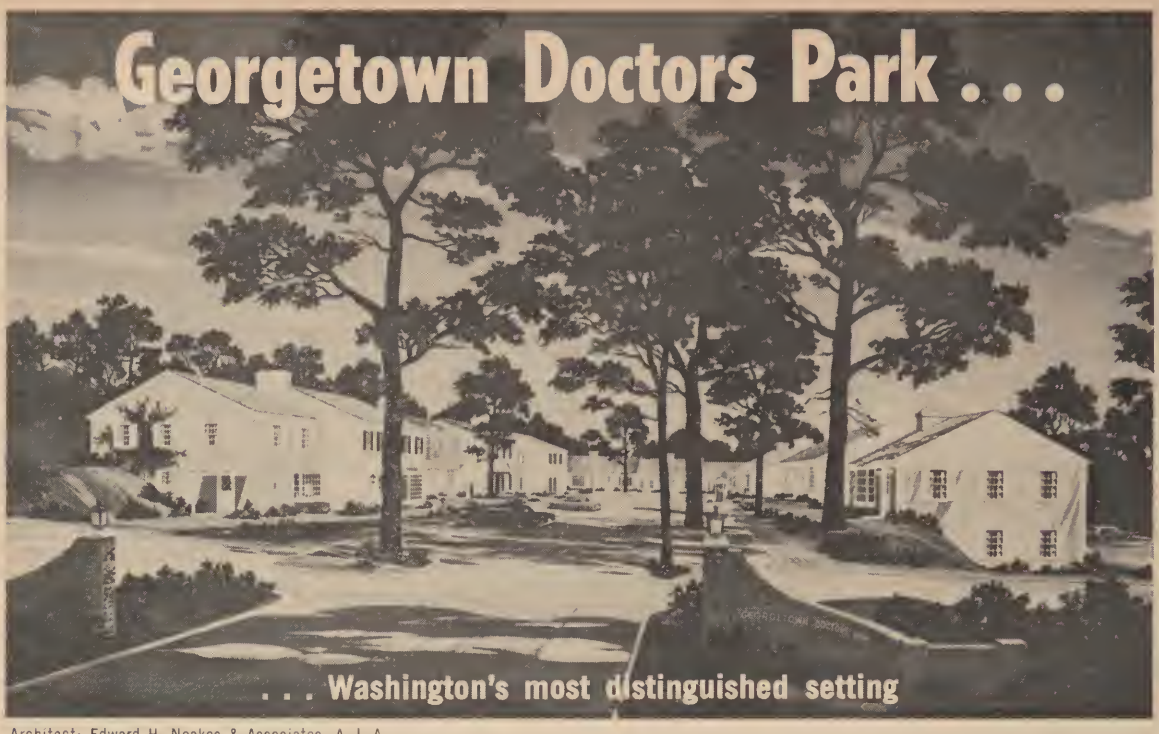
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

ALCOHOLISM INFORMATION WEEK

November 28-December 4

JOHN R. DAVIS, MD

For the past 20 years the National Council on Alcoholism has fought a relentless battle to destroy the stigma blinding the public to the true nature of alcoholism as a disease. In recent years, but most notably since 1964, there has been evidence that the stigma is beginning to fade and that the subject is coming into clearer focus.

One of the most effective tools created by the National Council for the use of its local affiliates in their year-round educational campaigns is the annual celebration of Alcoholism Information Week, scheduled this year to open November 28. In Maryland, the special activities of Alcoholism Information Week are being coordinated by the Baltimore Area Council on Alcoholism, with participation by a number of public and private agencies: the Baltimore City Health Department, the State Department of Mental Hygiene, and Councils on Alcoholism on the Eastern Shore and in Frederick, Montgomery, Prince George's, and Washington Counties. The slogan is **"Help Him Help Himself. Alcoholism is Treatable."**

THE PHYSICIAN'S ROLE

Since 1950, the American Medical Association has had an energetic committee working on the multiple problems of alcoholism. A similar committee, under the expert chairmanship of John H. Hirschfeld, MD, has been active for the past three years within the Medical and Chirurgical Faculty of Maryland. However, to quote from *Alcoholism: Its Facets and Phases,* by Marvin A. Block, MD, who chaired the AMA committee for 10 years:

> The organized profession itself can be of very little help unless the individual physician recognizes his responsibilities in his own community to the patient suffering from alcoholism. One thing is clear. He can no longer avoid this issue. He can no longer neglect these patients. He cannot pass the buck. He must treat them. There are methods, and satisfactory ones, of doing this. There is sufficient evidence that good results can be obtained. True, we cannot promise cures, since a cure would imply that the patient might be able to drink normally again. However, complete recovery can be attained by the patient with the help of his physician, and it is to this end that the doctor must work. Properly trained in the medical approach to this problem, and with sufficient psychiatric orientation, with which every modern physician today is equipped, he can achieve very satisfactory results with most patients.

The physician, whether in industry, public health, or private practice, is in an especially strong position to educate people about alcoholism. He sees and treats both alcoholics and their families, and in counseling such patients he reaches a substantial segment of his community. He can project throughout the year the facts on which Alcoholism Information Week will focus the at-

Dr. Davis is president, Baltimore Area Council on Alcoholism, and a member of the Board of Directors, National Council on Alcoholism. He is medical director for the Chesapeake & Potomac Telephone Company of Maryland.

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FACTS ABOUT ALCOHOLISM

Alcoholism is a progressive disease, calling for medical, psychiatric, and social help. Alcoholics are sick people, but they can be treated successfully. They can respond to treatment at any stage of the disease, and recover.

The U. S. Public Health Service ranks alcoholism among the four major health problems, along with cancer, mental illness, and heart disease. About 79,000,000 adults in this country drink, but drinking presents no problem to most of them. To about 5,000,000 of them, however, alcohol has become enough of a problem to interfere with their lives. These are the alcoholics, and because of their illness, the 20,000,000 members of their families, especially their children, are adversely affected.

There are many types of alcoholism and many types of alcoholics. The skid row derelict, though presenting a major sociomedical problem, represents but a small fraction of alcoholics in this country.

The incidence of alcoholism among employees in industry is 3-8%. The loss of work efficiency and the loss of valuable personnel who succumb to alcoholism after years of investment in their training cost industry an estimated two billion dollars a year. Wage losses though absenteeism in industry, due just to excessive drinking, have been computed at $432,000,000 a year. The total dollar costs of alcoholism to the nation are incalculable, yet they are exceeded by the human costs.

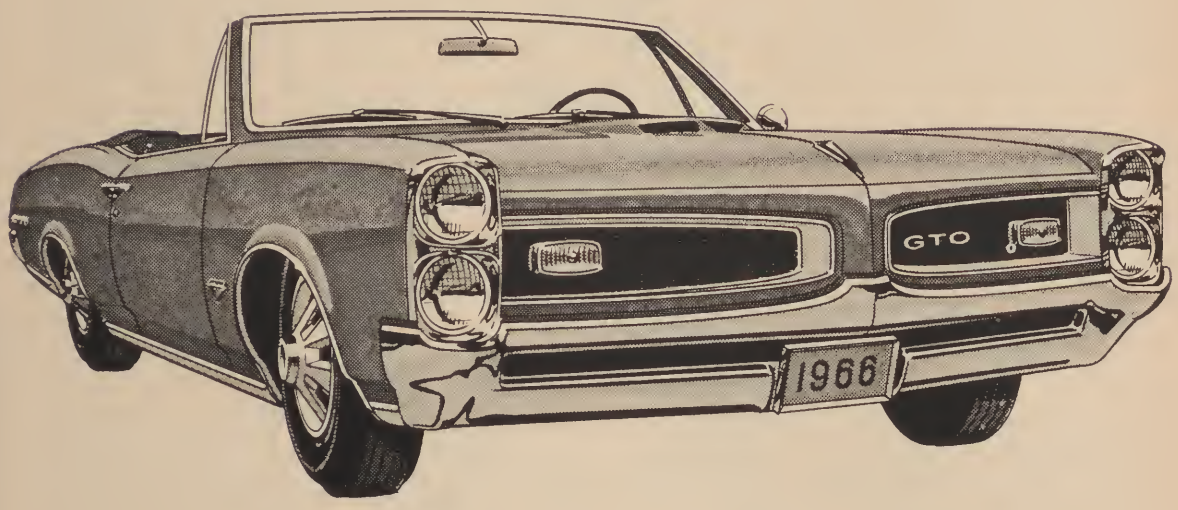
HELP FOR ALCOHOLICS

In Maryland there is help for alcoholics and their families in many public and private agencies. A convenient checklist for the practicing physician would include the following resources:

- His local health department, for clinical service or public health nursing service.
- The nearest council on alcoholism (The Baltimore Area Council, TU9-3553, can provide information).
- Alcoholics Anonymous (The Intergroup Office in Baltimore, 467-4667, can provide information).
- Al-Anon, for relatives of alcoholics (The state coordinator can be reached in Baltimore, 488-1649).

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Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



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As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

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And side effects, at recommended dosage, have been infrequent and generally readily controlled.

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Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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EYE DISORDERS IN HANDICAPPED CHILDREN

PETER A. GARDINER

The vision that almost every healthy adult uses in the prime of life is settled beforehand by events and processes occurring during his childhood (or before) and his adolescence. It is therefore in the interests of everybody's activities that all possible efforts be made to trace the causes of defective vision, to discover disorders early in their existence, and to follow up discovery with immediate appropriate treatment where it is possible. Where causes are not known and where methods of early detection or of treatment are inefficient, intense research is needed.

Early discovery of a lesion traditionally depends on the close study of symptomatology, but in eye defects like unilateral amblyopia, symptoms are sometimes absent in the young child or infant. Various consequences grow from the failure to detect a defect early: 1) The condition cannot be treated at the most favorable age; 2) the sensory input is defective during the formative years; and 3) the child becomes conditioned to a faulty mechanism, so that when measures are eventually taken, the conditioning has to be undone and visual acuity built up perhaps from scratch. Though it is possible to make up for lost time in some cases at later ages, it is clearly wrong that a child's information about the world should be faulty for so long and that his opportunities to learn basic visual skills in the most formative years should be restricted by the default or ignorance of his elders.

If this is the situation in normal children, how does it apply in the handicapped, by which I mean children with a constitutional disability of body or mind which limits normal development and function?

First, visual defects are much more common among handicapped children. In a school for these children, 60% of the brain-damaged had an eye lesion, 40% squinted, 28% were amblyopic, and 24% had difficulty in reading small print. Not only are more brain-damaged children hypermetropic than normal children, but also three times as many hypermetropic children among the brain-damaged squint as those among other physically handicapped children. Among children of school age with congenital heart disease but without brain damage, 22% of those with Fallot's tetralogy squint, 40% have some degree of amblyopia, and 60% have an eye lesion of some sort. Among children with congenital heart disease of all sorts, 20% are amblyopic, 12% squint, and 30% have some sort of an eye lesion.

Secondly, among handicapped children there is not only a higher incidence of defects than among normal children, but much more difficulty in making the diagnosis. These children are commonly thought impossible to test because of, say, speech difficulties or difficulties in understanding the test or manipulating the material. There are numerous examples at all schools for the physically handicapped and the mentally subnormal of undiscovered and unsuspected visual defects. Nobody knows how many among preschool children are in these categories because no screening is performed at earlier ages. This failure to diagnose eye defects, which would not be tolerated among healthy children, occurs partly because of the difficulties already mentioned and partly because concern for the general health of the child pushes consideration of his sight into the background. Another deterrent to discovery is the attitude that "the child has enough to put up with."

Abstracted from *Guy's Hospital Gazette*, 79: 356-360, July 24, 1965.

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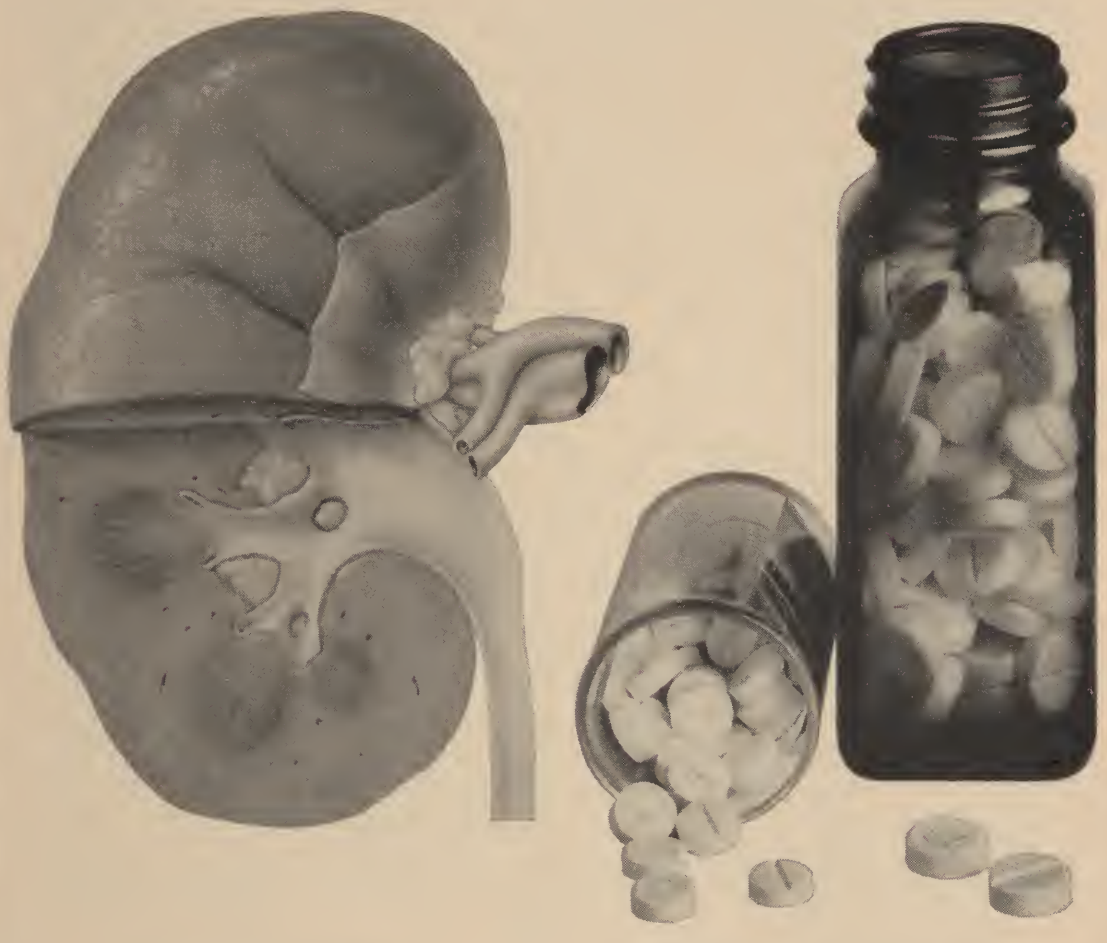
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Just how misguided this attitude is makes my third point—that the child handicapped in other ways may be more likely than a normal child to benefit from early good sight development. Vision so blurred that the young child cannot see his mother smile is a severe emotional deprivation, but for a child already handicapped in other ways it is surely a burden he could well be spared. In handicapped children who learn at a slower than normal pace, it seems logical that provision for good sight should be made from the youngest age possible in the hopes of removing one obstacle to learning about the world.

In the case of mentally handicapped children, we cannot always get sufficient cooperation to perform tests of visual acuity. In any case, defective interpretation may prevent them from signifying whether images are clear or blurred. In one school for mentally defective children, however, more than 50% of those for whom glasses were prescribed because of refractive errors were wearing them after three months. Some of these children become employable as adults, and one of their favored occupations is making small parts for computers, which requires excellent visual acuity.

I hope that I have made the case that handicapped children, in whom defects are more common, more difficult to diagnose, and equally if not more important to treat than in normal children, constitute a special group with an increased risk warranting special efforts and special measures to detect defects early. When this need is recognized, it seems to me that early diagnosis, usually in the absence of symptoms, can only be made by setting up special screening clinics for young children, such as the handicapped, who are known to have an increased risk of visual defect and an increased need for first class vision. In the absence of these clinics, any doctor, if he sends *all* his patients with brain damage to an ophthalmologist at the optimum age, which is two to three years, will be right more often than wrong if he says he suspects an eye lesion—even without looking at the child. In the presence of symptoms, referral should be earlier, of course.

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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 6: Unattended Delivery

This 41-year-old patient, parity not stated, lived about 15 miles from the community hospital in her area and from the local health center. The brief history that could be obtained follows: She apparently made no effort to obtain prenatal care during the pregnancy, nor had she made any arrangements for delivery. Labor is stated to have begun at approximately 1 AM on January 14. Her husband walked one and a half miles to the nearest telephone to call the local rescue squad. The rescue squad had difficulty in finding the patient's home. When it finally arrived, the patient had delivered spontaneously a living male infant and was bleeding profusely, with the placenta still *in utero*. One of the squad attendants tied the cord, and the patient and infant were taken promptly to the nearest hospital, where she was pronounced dead 10 minutes after arrival.

COMMENT

It is shocking to record an event of this type in the mid 20th Century. The community in which this patient lived, although remote, is not devoid of either practicing physicians, a hospital, licensed midwives, or health centers. The Committee members obviously voted this as a clearly preventable maternal death, with the responsibility assigned to the patient for her gross negligence in failing to seek medical care during pregnancy.

This case dramatically illustrates the tragic sequelae that frequently occur in patients who have received no prenatal care. After 40 years or more of educational efforts to induce women to seek medical care early in pregnancy, there is still a disturbingly large number of women who await the onset of labor before making any attempt to seek help. This pattern is responsible not only for maternal deaths but also for the unnecessarily high perinatal mortality and the high percentage of prematurely born and damaged infants.

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Highlights

EASTERN ENCEPHALITIS

In June, the Division of Epidemiology alerted physicians, hospitals, and public health officials to the possibility of cases of mosquito-borne encephalitis occurring in Maryland. Services of the laboratory were made available to aid in diagnosis.

During the first week in September, Eastern encephalitis was discovered in birds on an Eastern Shore pheasant and chukar game farm. Four cases in horses have occurred in this area in the past three weeks. Preventive measuers were promptly initiated, including quarantine, disposal of sick birds, vaccination of pheasants, chukars, and horses, and mosquito control. A shipment of birds from the infected flock brought to the Western Shore was destroyed as soon as the outbreak was diagnosed.

Although no case of mosquito-borne encephalitis in humans has been reported this year in Maryland, the possibility of human cases will continue to exist until cold weather ends the mosquito season.

RABIES

During the first 37 weeks of 1965, 22 cases of rabies in animals have been reported. During the same period of 1964, only one such case was reported. Most of the 1965 cases occurred in bats; however, transmission of the virus to other wild and domestic animals and to humans constitutes a threat.

County health departments now sponsoring rabies vaccination clinics for dogs are: Carroll, Cecil, Frederick, Harford, Howard, Montgomery, Prince George's, and Wicomico.

HEALTH EXAMINATION SURVEY OF CHILDREN

The Public Health Service's Health Examination Survey, authorized by Congress in 1956, is examining a sample of 6-11 year old children in Sussex County, Del. and Worcester County, Md. The four-week survey began October 25 and is part of a nationwide sampling study of children. About 200 children from these two counties have been chosen by a scientific sampling process.

Examinations are being given in the Health Examination Survey's Mobile Examination Center, composed of four medically-equipped trailers, set up at the corner of South Bedford and East Pine Streets in Georgetown, Del.

Purpose of the survey is to collect uniformly statistical information on various aspects of children's health and to obtain data on certain physical and physiological measurements of these children, relating to growth and development.

The process includes a specially designed limited examination by a pediatrician to detect neuromuscular and joint conditions and heart disease; a dental examination by a dentist; a test of visual acuity and color vision; an audiometric test performed in a soundproof room; an x-ray of the wrist for bone age; an x-ray of the chest for cardiovascular and pulmonary abnormalities; a 10-lead electrocardiogram; a test of vital capacity, using a spirometer; an exercise tolerance test under a measured workload, using a bicycle ergometer; a grip-strength test; recordings of height, weight, skinfold thickness, and various other anthropometric measurements; and a series of psychometric tests administered by a psychologist.

The Health Examination Survey is designed



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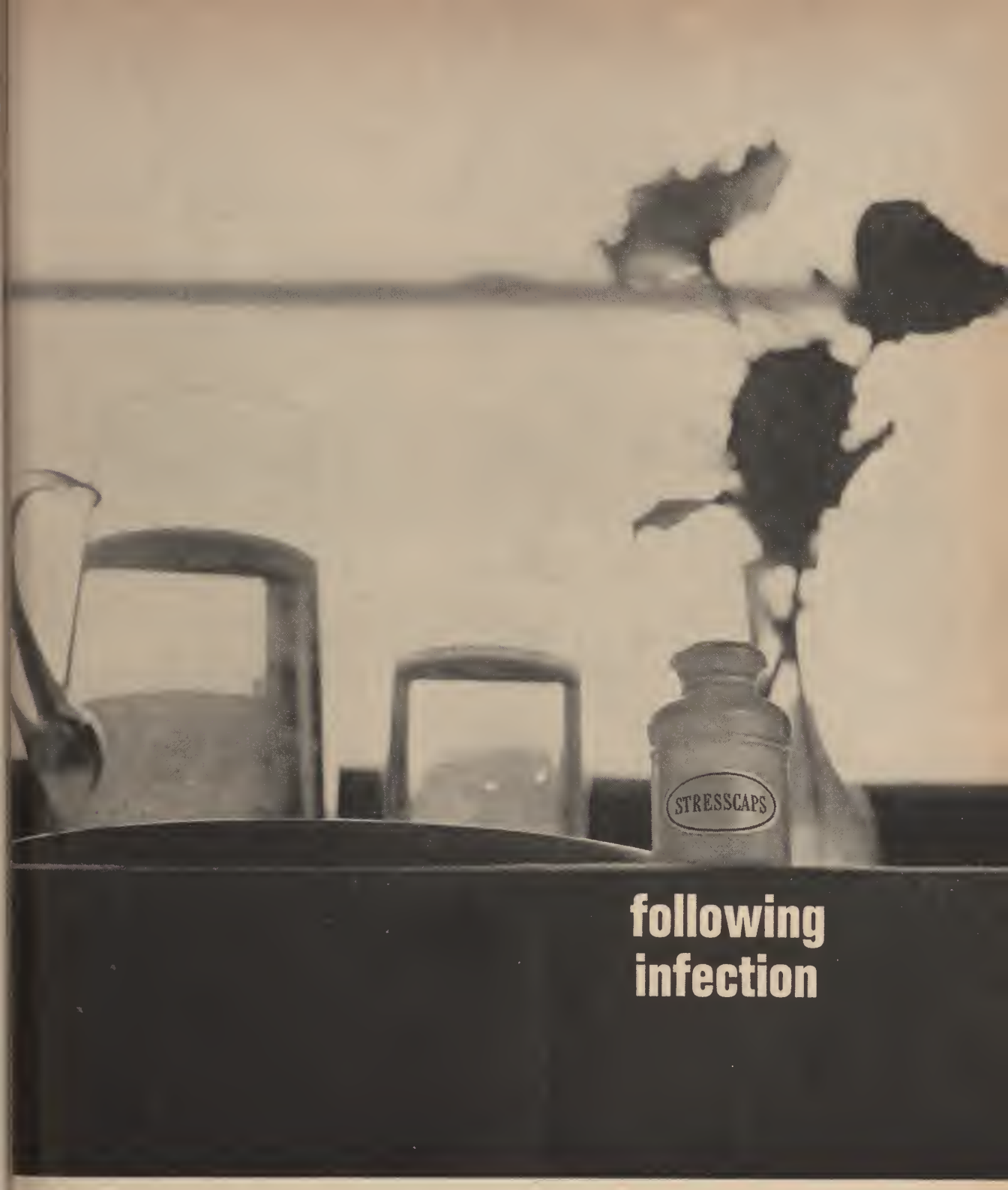
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to collect data primarily on growth and development. It is not intended as a screening procedure; referral for diagnosis is not made. The fact that the examination is not complete and is not a substitute for a visit to one's own physician and dentist is stressed with the parents of each child examined. A report of findings will be sent to the child's physician and dentist when the parent request that this be done.

The examining physicians are fellows or senior residents in pediatrics working temporarily with the Public Health Service. Other members of the team include nurses, a dentist, two psychologists, and x-ray and other technicians regularly on the PHS staff.

Pharmaceutical manufacturers, provide scores of publications to teachers, students, public speakers and others. Titles range from "Poison Ivy—The Summer Itch" to "Good Teeth for Your Child" to "Benjamin Minge Duggar, Discoverer of Aureomycin," according to the Pharmaceutical Manufacturers Association in Washington, D. C.



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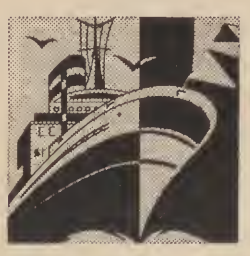
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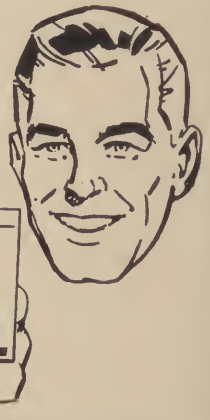
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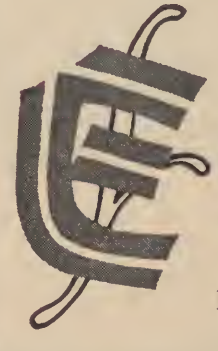
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Résumé of Infant and Maternal Mortality

January-June, 1965

The City Health Department's Bureau of Biostatistics, under the direction of Miss Elizabeth Kelley, has prepared the following résumé of infant and maternal mortality for the first six months of 1965.

Infant mortality in this period was 31.4 per 1,000 live births, a 6.4% increase over the rate for the comparable period of 1964 and the highest rate for this period since 1962. According to the Monthly Vital Statistics Report from the National Center for Health Statistics, infant mortality in the United States for the period January-May was about 4% higher than the rate for the same period of 1964.

An increase in mortality of white infants was responsible for the higher total rate. The white rate increased from 22.6 in 1964 to 29.8 in 1965, while the nonwhite rate decreased from 36.4 in 1964 to 33.0 in 1965. Both the neonatal and post-neonatal components of white infant mortality increased. The white neonatal mortality of 21.8 per 1,000 live births is the highest experienced among white births during the present decade, and the white post-neonatal rate of 8.0 is the highest since 1960.

Only one maternal death occurred during the first half of 1965 compared to seven in 1964 and four in 1963.

Robert E. Farber, MD
Commissioner of Health

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STATE OF MARYLAND

Department of Mental Hygiene

The Hospitalized Mentally Subnormal

Approximately five million Americans are mentally deficient; that is, their intelligence quotient (IQ) as measured by presently employed tests is less than 70. To this are added every year more than 100,000 babies who are mentally subnormal from birth. About 2,000 are born to Maryland parents. In addition, many children who are mentally normal at birth become functionally retarded because of cultural, economic, and social deprivation.

Most of the retarded are in the highest group; having an IQ level between 50 and 69. It is believed that five out of every six could be trained and educated to function as community and family members if adequate resources were provided for such programs and for necessary supportive services.

Rosewood and Henryton are Maryland's major hospital facilities for the mentally retarded. Their patient population exceeds 2,800 and is increasing at an annual rate of more than 100. In addition, 60 children receive care in private facilities. The largest, Angel's Haven, has 25 patients. There are also 700 psychotic and non-psychotic retarded patients in the state psychiatric hospitals.

It is estimated that at least 1.0 bed per 1,000 total population is needed for the care of the mentally retarded. The number of beds for retarded patients has doubled in the last 10 years. Despite this, Maryland now has 0.8 beds for every 1,000 residents. This figure is 15% below the national average and is lower than that in 33 other states. Delaware, New York, and 17 other states exceed it by more than one-third. Currently approved construction at Rosewood and in the Washington suburban area will raise this ratio slightly to 0.9 by 1968.

Under present conditions, the number of retarded in Maryland requiring inpatient services is expected to continue to increase. The immediate need, therefore, is for the continuing construction and staffing of additional facilities. The ultimate solution rests upon five major factors:

1. Research into the causes and means of prevention of mental deficiency.
2. Expanded and intensified prenatal services for expectant mothers known to have a high probability of having a premature delivery. The incidence of mental retardation is very much higher among premature births than among full term deliveries of normal weight.
3. The success of the new programs to minimize cultural, economic, and social deprivation.
4. Increased training and educational programs for the retarded to permit the maximum development of their potential.
5. The establishment and expansion of closely coordinated community centered facilities and supportive services, such as day care centers, half-way houses, sheltered workshops, group care homes, small residential facilities, and other suitable substitutes for hospitalization.

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The Art of Giving

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Thanksgiving Day is near, and the Christmas season is not far behind. Physicians are beginning to ask these questions:

What should I give to referring colleagues, patients, and friends that is a little different than usual?

What should I do about gifts to interns, residents, and nurses who assist me?

Should I give my office staff a personal gift or cash?

What are the limitations on professional gifts under the present tax rules?

To answer the last question first, deductions for gifts to referring colleagues, patients, and friends, as well as to interns, residents, and nurses are limited annually to $25 a person. The $25 limitation affects a partnership as well as a solo practitioner in that the partnership cannot exceed $25 a person annually, regardless of the number of partners. You can, of course, give a more expensive gift to valued, helpful friends, but you may deduct no more than $25. These rules do not apply to employees.

In response to the first question, gifts to referral sources should be useful and practical. Clocks, elaborate ash trays, brief cases, transistor radios, and electric knives, can openers, and tooth brushes are but a few of the long list of gifts almost anyone would like to receive.

Gifts for an intern or resident sometimes present a problem. Practically speaking, there could be no finer or more useful gift than a certificate to one of the better local restaurants. Even if he should receive more than one such gift, the odds are that each one will be thoroughly enjoyed and probably at a place he might not otherwise go because of his limited time and budget.

For the nurse, again a gift certificate, but this time from one of the large department stores where she can purchase the toiletries or other items personally needed but not found under the Christmas tree.

The third question concerns most physicians. If you give an employee cash, it does not come within the $25 annual gift limitation rule. However, if you wish to deduct the amount given as a gift, it must be reported on the recipient's W-2 slip for income tax purposes. Gifts of tangible personal property, such as a watch, portable typewriter, tape recorder, or radio, costing no more than $100 and given for "loyalty" or "devotion to duties" are not included in figuring the $25 limitation.

Whatever you decide, make your decision early. If it is to be a gift, try to learn what she really needs. If it is to be cash, give it at least two weeks before the holiday. It may be the answer to her gift budget, and she won't die of anticipation.

So that you may achieve the art of giving keep the following thoughts in mind:

1. Have I included everyone on my list so I will not offend a single person?

2. Have I reviewed my list of gifts with my business advisor to make sure I have stayed within the rules as prescribed by law?

Entertainment is important at this time of year. Entertaining small intimate groups, especially in your home, adds a personal warmth to the season. Sunday brunch or a late evening dinner are ideal occasions.

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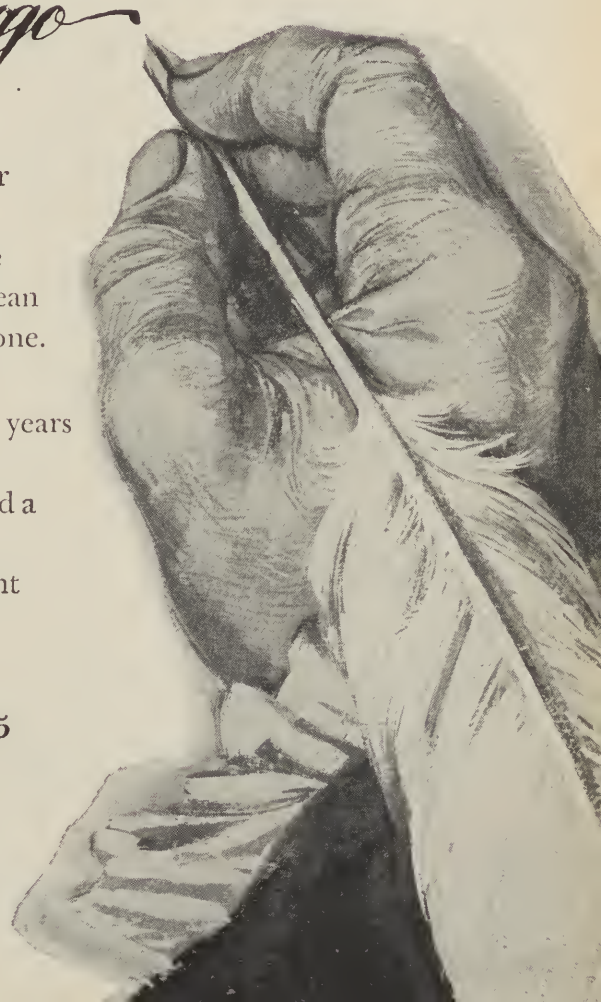
Remember, in order to justify a deduction for professional entertainment, you must be able to prove that the occasion took place in surroundings conducive to entertaining. You also must be able to provide a detailed list of those entertained and an itemized explanation of all expenses.

What is the single most important contribution to drug research?

It was made 175 years ago

when President Washington signed the first U.S. patent law. For patents mean drug progress. For example, of the 604 important drugs introduced worldwide since 1941, the majority originated in the U.S. drug industry. By contrast, a major west European nation, which has no patent protection, contributed one.

How great is the contribution of drug patents? The answer is told in life itself: our children live 10 years longer than we, and need not suffer polio, measles, diphtheria, tuberculosis, rheumatic heart disease, and a dozen other illnesses we grew up fearing. We can expect these benefits to multiply—as long as our patent system remains strong.



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LIBRARY REVIVES VISITS TO COUNTY MEDICAL SOCIETY MEETINGS

Beginning this fall, the Medical and Chirurgical Faculty Library was represented at the regular meetings of the county medical societies, giving physicians in those areas the opportunity to see new books, to become acquainted with the librarians personally, and to register their requirements or complaints.

We believe this will be a distinct improvement over trying to communicate entirely by mail or telephone. If member physicians will submit special requests to the library before a scheduled meeting date, the librarian, Mrs. Elizabeth Sanford, or the assistant librarian, Mrs. Gloria Miller, will bring the requested books or journals to the meeting.

December meetings are scheduled for Calvert, Caroline, and St. Mary's counties. Weather permitting, there will be a librarian and a selection of books of interest at these meetings.

* * * * *

On November 17, the Hospital Librarians of Metropolitan Baltimore met at the Medical and Chirurgical Faculty Library to discuss "The Role of the Medical Society in Library Service." Louis Krause, MD, chairman of the Library and History Committee, spoke from the standpoint of the physician. Mrs. Sanford reported briefly on the workshop on "Information Needs of the Practicing Physician," held by AMA in Chicago on May 10.

* * * * *

The Washington-Maryland-Virginia regional meeting of the Medical Library Association met in Charlottesville, Va., on October 23, to discuss "Upgrading a Rundown Medical Library." Although our library is not in this category, new ideas and procedures emerge from the discussion, and such a gathering of authorities is both stimulating and helpful.

* * * * *

The Medical Library Assistance Act of 1965 has passed both houses of Congress.

RECENT ACCESSIONS

American College of Surgeons: *Management of fractures and soft tissue injuries,* 2d ed, Saunders, 1965.
Allergy and Hypersensitivity, a programmed review for physicians, 2d ed, Pfizer Laboratories, 1964.
Robin Anderson and L. T. Byars: *Surgery of the parotid gland,* Mosby, 1965.
William P. Beetham: *Physical examination of the joints,* Saunders, 1965.
Eric Berne: *Games people play,* Grove Press, 1964.
A. L. Blonstein: *Medical aspects of boxing,* Pergamon Press, 1965.
Mary Brazier: *Brain function, Vol II: RNA and brain function memory and learning,* Univ. of California Press, 1964.
William J. Curran: Tracy's *The doctor as a witness,* 2d ed, Saunders, 1965.
Current concepts of thyroid disease, a programmed self-instructional review for physicians, Pfizer Laboratories, 1965.
Henry Davidson: *Opportunities in a psychiatry career,* Vocational Guidance Manuals, 1964.
Scott A. Earle: *Surgery in America,* Saunders, 1965.
Gerald Fonda: *Management of the patient with subnormal vision,* Mosby, 1965.
W. I. Gefter: *Synopsis of cardiology,* Mosby, 1965.
J. P. Greenhill: *Obstetrics,* 13th ed, Saunders, 1965.
William Harris, W. Jones, and O. Aufranc: *Fracture problems,* Mosby, 1965.
Walter Hess: *Surgery of the biliary passages and the pancreas,* Van Nostrand, 1965.
Herman E. Hilleboe and G. W. Larimore: *Preventive medicine: principles of prevention in the occurrence and progression of disease,* 2d ed, Saunders, 1965.
Warren Johnson: *Human sex and sex education,* Lea & Febiger, 1963.



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H. Kelikian: *Hallux valgus, allied deformities of the forefoot and metatarsalgia,* Saunders, 1965.

Thomas Keys: *The history of surgical anesthesia,* Dover, 1963.

Lawrence E. Lamb: *Electrocardiography and vectorcardiography,* 1965.

Aldo Luisada: *From auscultation to phonocardiography,* Mosby, 1965.

Gordon F. Madding and P. A. Kennedy: *Trauma to the liver,* Saunders, 1965.

Milton Markowitz and A. G. Kuttner: *Rheumatic fever: diagnosis, management, and prevention,* Saunders, 1965.

Frank Newell: *Ophthalmology: principles and concepts,* Mosby, 1965.

Myron Prinzmetal: *Heart attack: new hope, new knowledge, new life,* Simon & Schuster, 1958.

Jean J. Rutherford and R. N. Rutherford: *Consultations with your doctor for personal understanding of marriage,* Budlong Press, 1964.

John S. Spratt: *Anatomy and surgical technique of groin dissection,* Mosby, 1965.

Howard S. Traiman: *Management of juvenile diabetes mellitus,* Mosby, 1965.

Joseph Trainer: *Physiologic foundations for marriage counseling,* Mosby, 1965.

George Ulett and D. Wells Goodrich: *A synopsis of contemporary psychiatry,* 3d ed, Mosby, 1965.

George A. Ulett and D. B. Peterson: *Applied hypnosis and positive suggestion,* Mosby, 1965.

John Ullery and Z. Hollenbeck: *Textbook of obstetrics,* Mosby, 1965.

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Woman's Auxiliary

NOVEMBER, 1965

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Mrs. Louis Moody

President, Woman's Auxiliary to the Prince George's County Medical Society



Iris Moody is a native of Washington, DC. She attended the Takoma-Silver Spring High School and was graduated from the University of Maryland in 1937 with a degree in Business Administration. She was a member of the Alpha Xi Delta sorority.

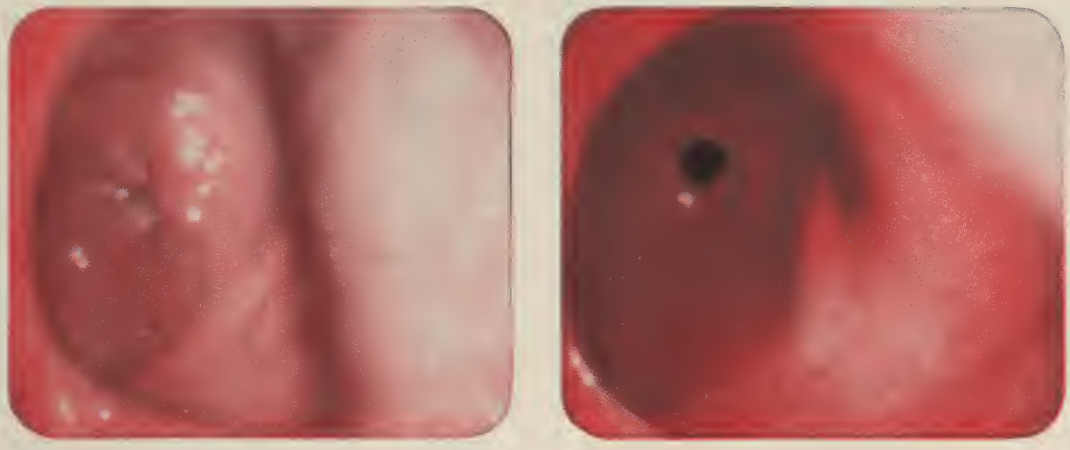
Iris met her husband while at the University of Maryland, and they were married in 1937. He was then a freshman at the George Washington Medical School. She worked as a "jack-of-all trades" for a Chevrolet dealer after graduation and then with the Department of Justice for five years.

After completing a residency in OB-GYN, Dr. Moody joined the Air Force in 1942 and spent 16 months in Alaska, where no women were permitted.

Louis Edward Moody, the oldest son, was born in 1941. He was graduated from Georgia Tech and married a "Georgia Peach" in 1964. He is now a design engineer for an electronics company in Philadelphia. The Moody's second son, Chris Alan, was born in 1946. He has begun his second year of pre-dentistry at the University of Maryland.

Between 1946 and the birth of their third son, Dennis Brian, in 1952, Dr. Moody finished his residency and entered private practice. Dennis, an eighth grade student, seems to favor veterinary medicine.

Iris has worked with PTA, church bizarre, and Cub Scouts. In the Prince George's County Auxiliary, she has been chairman of Membership, Doctor's Day, and Publicity, as well as secretary and treasurer, before assuming her role of president.



Intragastric photography studies[1]

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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

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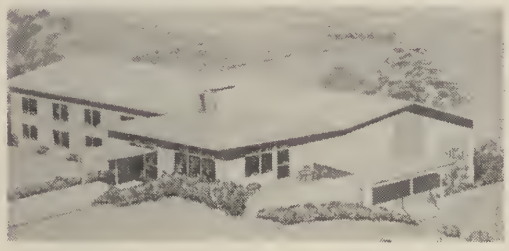


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(1) Portnoy, J.; Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAB., *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.



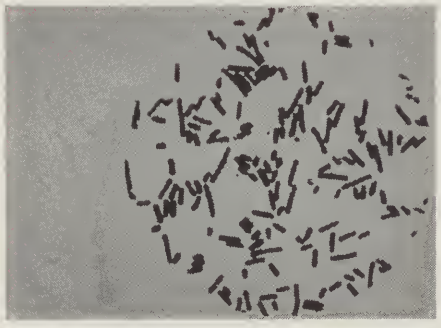
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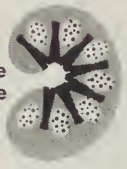
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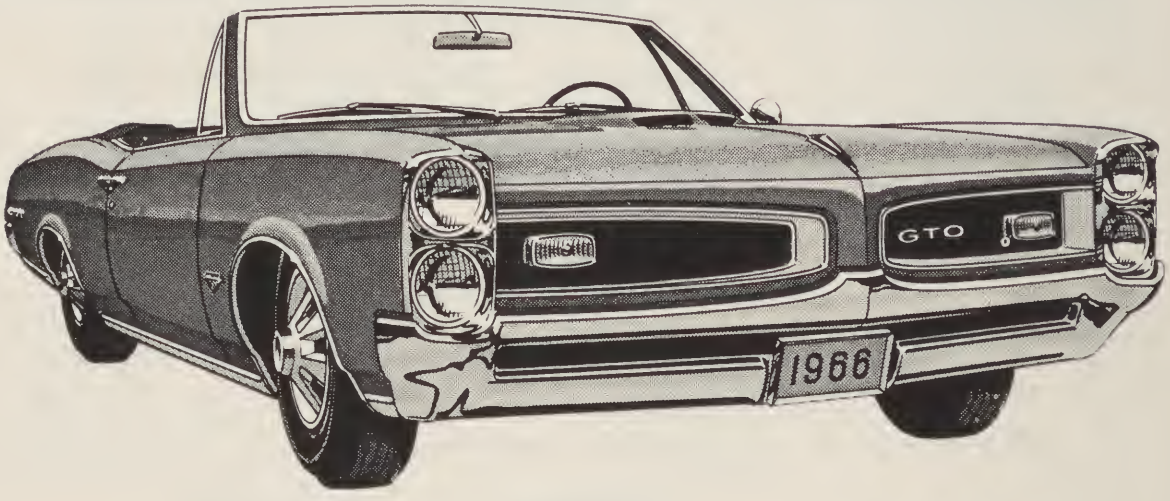
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April 27-Moy 4, 1966—Annuol meeting, Medicol ond Chirurgicol Foculty of the Stote of Morylond.
April 27-28, Baltimore—April 29-May 4, Aboard ship ond in Bermudo

MARYLAND EAR, NOSE AND THROAT SOCIETY

January 5—8 PM—Sheraton Belvedere Hotel

"Portiol Laryngectomy," Joseph H. Oguro, MD, professor ond heod of the Deportment of Otoloryngology, Woshington University School of Medicine, St. Louis. Preceding the meeting: cocktoils at 6:30 and dinner ot 7.

BALTIMORE CITY MEDICAL SOCIETY

January 7—8:30 PM—1211 Cathedrol St., Boltimore

"Suppurative Infections of the Liver and Biliary Tract," Theodore E. Woodward, MD, professor of medicine and head of the department, University of Maryland School of Medicine.

"Management of Portal Hypertensian ond Its Complications," Geargе D. Zuidema, MD, professor of surgery ond directar of the Department of Surgery, The Johns Hopkins University School of Medicine.

MARYLAND PEDIATRIC SOCIETY

January 11—1211 Cathedral St., Boltimore

Annual Dinner Meeting. "What is Chronic Nephritis in Childhood?" Wollace W. McCrory, MD, professor and chairman, Department of Pediatrics, Cornell University Medical College.

HEART ASSOCIATION OF THE LOWER EASTERN SHORE

Jonuory 14

Teoching sessions for physicians: "Modern Diagnostic Methods in Cardiology," Donold Fisher, MD.

BALTIMORE CITY DENTAL SOCIETY

January 12—Sheroton Belvedere Hotel, Baltimore

3 PM—"Dentist and The Low—A Mock Court Triol," Normon Romsey, Esq.
5:30 PM—Business Meeting
6 PM—Cocktoils and Dinner
7:30 PM—Table clinics with the Laboratory Guild

ARIZONA HEART ASSOCIATION

Jonuory 28-29—Phoenix

Ninth annual cordioc symposium, to be held in the Del Webb Towne House. Arizono Heort Association, 2824 N 16th St, Phoenix, Ariz 85006.

UNIVERSITY OF MARYLAND

5. ADVANCES IN MEDICAL SCIENCE—January 12-March 30

Designed for physicians in practice who wish to review the important advances in medical science. Emphasis is placed on a basic scientific approach to an understanding of the more common clinical problems and their management.

6. DERMATOLOGY DAY—January 20

Under direction of H. M. Robinson, Jr., MD: A clinical session in which many dermatalogic disorders will be seen and examined by the attending physicians, followed by presentation and discussion of the problems of diagnosis and management of each entity.

7. CLINICAL ANATOMY—February 2 through May 25

Under direction of Otto C. Brantigan, MD: Emphasizing the practical application of anatomy and anatomical principles in physical and x-ray diagnosis. Anatomical knowledge is related to the use of needling in performing diagnostic procedures and in treatment. The course is directed toward both the medical man and the surgeon. It is an aid in preparation for the American Baard Exam.

8. OBSTETRICS—February 10

Under direction of Edmund B. Middleton, MD: Problems of obstetrical management in the prenatal period and at the time af delivery will be considered.

9. HEMATOLOGY—March 10

Under direction of Carroll L. Spurling, MD: A basic review of diseases of the hemopoietic system. Illustrative peripheral blood and bone marrow slides will be used in connection with selected case material. Newer techniques of diagnosis and treatment will be discussed.

MEDICAL COLLEGE OF GEORGIA

PEDIATRICS—January 25-26

This program presents recently developed knowledge about diseases of children that has application to clinical patient care. It is anticipated that this course will be of particular interest to pediatricians and other medical practitioners engaged in the care of children. The coordinator for the professional content of the course is Gerald H. Holman, MD, professor and chairman of the Department of Pediatrics, Medical College of Georgia.

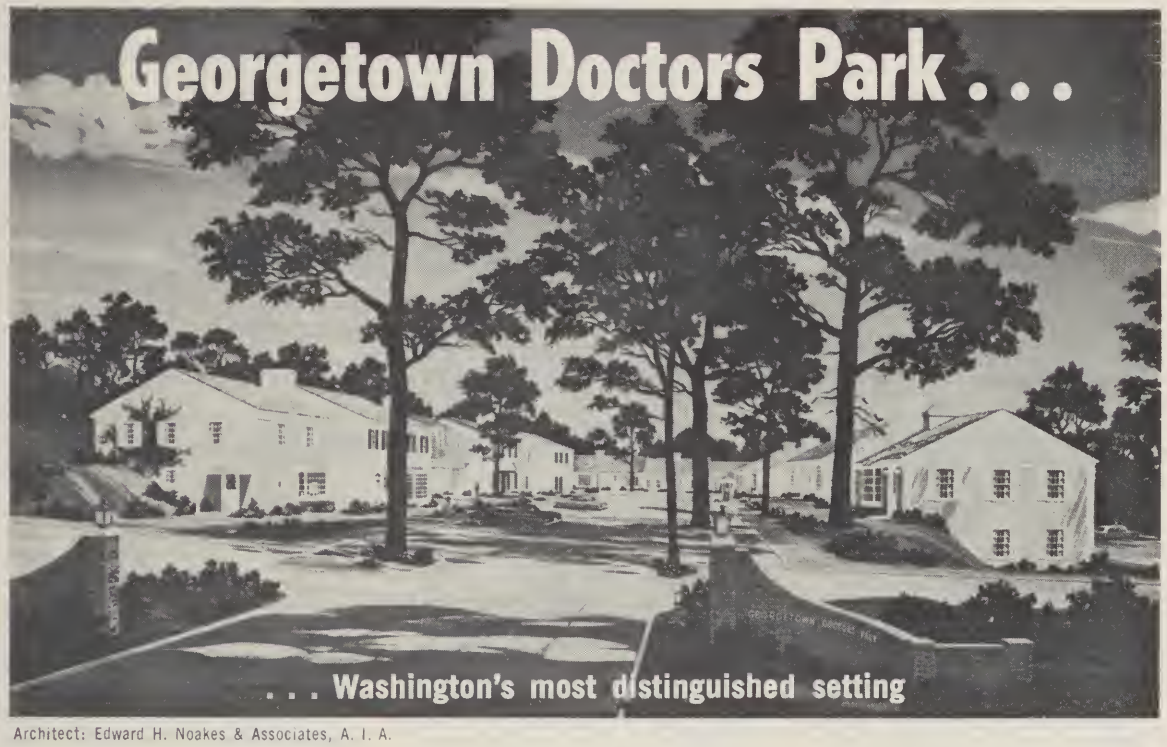
AMERICAN COLLEGE OF PHYSICIANS

Course No. 10—CURRENT CONCEPTS OF INFECTIOUS DISEASES, February 7-11, Jefferson Medical College, Philadelphia.

Course No. 11—MEDICAL GENETICS, February 14-18, The Johns Hopkins University School of Medicine.

Course No. 12—CANCER, February 21-25, Presbyterian-St. Luke's Hospital, Chicago.

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Robinhold, Daniel Guy, 1519 E. Monument St., Baltimore, Md. 21205

Robinson, E. Ann, 216 Northway, Baltimore, Md. 21218

Rockwell, William J. K., 2117 Huidekoper Pl., N.W., Washington, D. C. 20007

Rodriguez, Celestino J., 23-27 Whitestone Pkwy., Whitestone, N. Y. 11357

Rosario, Arnulfo S., 3134 Laurel Ave., Cheverly, Md. 20785

Rosenstein, Alfred B., 3526 Langrehr Rd., Baltimore, Md. 21207

Rosenstein, Gladys, River House, B1510, 1600 S. Joyce St., Arlington, Va. 22202

Rosenstein, Herman, River House, B-1510, 1600 S. Joyce St., Arlington, Va. 22202

Roth, Daniel George, 715 S.E. 2nd Avenue, Delray Beach, Fla. 33444

Ryan, Stephen J., Jr., Bellevue Hospital, 1st Ave. & 27th St., N. Y., N. Y. 10016

Saiontz, Henry Allan, 4120 Belle Ave., Baltimore, Md. 21215

Sattenspiel, Sigmund L., 3001 South Pkwy, Apt. 1113, Chicago, Ill. 60616

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Schruefer, John J., 1535 E. Monument St., Baltimore, Md. 21205

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Schwarz, Herbert, 5920 E. Pratt St., Baltimore, Md. 21224

Seff, David Joseph, 2422 Liberty Heights Ave., Baltimore, Md. 21215

Segal, Hannah Joan, 700 Sturgis Pl., Baltimore, Md. 21208

Selsky, Leonard, 12 Ocean View Terrace, Lynn, Mass.

Shelton, Perry S., 312 Stevenson Lane, Apt. 312-C2, Towson, Md. 21204

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Shope, Earl Samuel, 1566 Gusty Ct., Johnstown, Pa. 15905

Signor, William E., 4909 Parkton Ct., Baltimore, Md. 21229

Sjolund, George C., 3011 Ferndale Ave., Baltimore, Md. 21207

Smith, D. Edwards, White Plains, New Kent, Va.

Smith, Dorsett O., 4101 The Alameda, Baltimore, Md. 21218

Smith, Roger M. F., 1165 Madison St., Apt. B-1, Annapolis, Md.

Snell, Henry Madison, Capt. MC, USA, 2nd Army Medical Laboratory, Ft. Geo. G. Meade, Md. 20755

Snyder, Larry A., 3625 Valley Terrace, A-3, Baltimore, Md. 21207

Snyder, Solomon H., 3639 Paskin Pl., Apt. 6-B, Baltimore, Md. 21207

Sothoron, Warren H., Jr., 6306 Lone Oak Dr., Bethesda, Md. 20014

Stasiowski, M. Peter, 1240 Leeds Terr., Baltimore, Md. 21227

Steele, Thomas E., 8817 Hunting Lane, #201, Laurel, Md. 20810

Steffy, John M., 908 Nottingham Rd., Baltimore, Md. 21229

Stein, Harry C., 3405 Toledo Terr., Apt. E-1, Hyattsville, Md.

Steinberg, Harry Robert, 1311 Delaware Ave., S.W., Washington, D. C.

Steinberg, Louis E., 2067 N.W. Lovejoy, Portland, Ore.

Strasburger, Arthur K., 3515 E. 6th Ave. Denver, Colo. 80206

Strauch, Barry S., The Yale-New Haven Medical Center, New Haven, Conn. 06511

Strom, Leroy, 12403 Stretton Lane, Bowie, Md.

Sugar, Fred N., 730 Milford Mill Rd., Baltimore, Md. 21208

Taub, Albert Hiram, Mental Hygiene Consultation Service, Fort Belvoir, Va. 22060

Taylor, Britton Edgar, USNA, Perry Circle H-5, Annapolis, Md.

Thompson, Robert Sharpe, 609 N. Caroline St., Baltimore, Md. 21205

Thompson, W. Leigh, 550 N. Broadway, #505, Baltimore, Md. 21205

Tischler, Gary Lowell, 5511 Alta Vista Rd., Bethesda, Md.

Tokar, Elliot S., 4904 Challedon Rd., Baltimore, Md. 21201

Tomasulo, Joseph, 130 E. Ft. Lee Rd., Bogota, N. J. 07603

Toskes, Phillip P., 1103 Glencagle Rd., Baltimore, Md. 21212

Trillo, Raul Arturo, 307 Central Ave., Orange, N. J. 07050

Trupp, Mason, 329 E. Davis Blvd., Tampa, Fla. 33606

Tyson, Roger Lindelle, 5720 29th Avenue, Hyattsville, Md.

Verkouw, Peter F., 1316 Stonewood Rd., Baltimore, Md. 21212

Villafana-Justicia, Carlos, 8559 Glenn Dale Rd., Greenbelt, Md. 20717

Wagner, John Raymond, 607 N. Caroline St., Baltimore, Md. 21205

Walsh, John Walter, 9301 Wisconsin Ave., Bethesda, Md.

Walter, Robert M., Jr., 5715 S. Drexel Ave., Chicago, Ill. 60637

Weinstock, Joseph S., 4906 Challedon Rd., A-2, Baltimore, Md. 21207

Weisfeldt, Myron L., 5700 Arlington Ave., Apt. 2E, Bronx, N. Y. 10471

Weitz, Jean Walters, 3760 University Way, N.E., Apt. 116, Seattle, Wash. 98105

Whelan, Philip Joseph, 213-C Preston Ct., Baltimore, Md.

White, Kerr Lachlan, 1527 Park Ave., Baltimore, Md. 21217

Whitlock, Robert N., 1650 E. Belvedere, Apt. 203, Baltimore, Md. 21212

Willen, Abner, Clark Medical Center, Clark, S. D. 57225

Williams, Alfred J., 815 E. 215th St., Bronx 67, N. Y.

Williams, Irving Cardinal, 2847 N. Farwell Ave., Milwaukee, Wis. 53211

Willoughby, William F., II, 550 N. Broadway, Apt. 612, Baltimore, Md. 21205

Wilsey, John Derrick, P. O. Box 113, Edgewood, Md. 21040

Wimmer, William Carey, 4917 Challedon Rd., B-2, Baltimore, Md. 21207

Winkle, Ronald S., 9221 37th Ave., S., Seattle, Wash.

Woodward, William E., 2114 Sharon Dale Dr., Nashville, Tenn.

Wright, Jessie, Royal Acres, Royal Oak, Md.

Yamaner, Yilmaz, 3400 Toledo Terrace, Apt. J-6, Hyattsville, Md.

Zizic, Thomas Michael, 537 N. Washington St., Baltimore, Md. 21205

Zollicoffer, Lawrence, 3814 Park Heights Ave., Baltimore, Md. 21215

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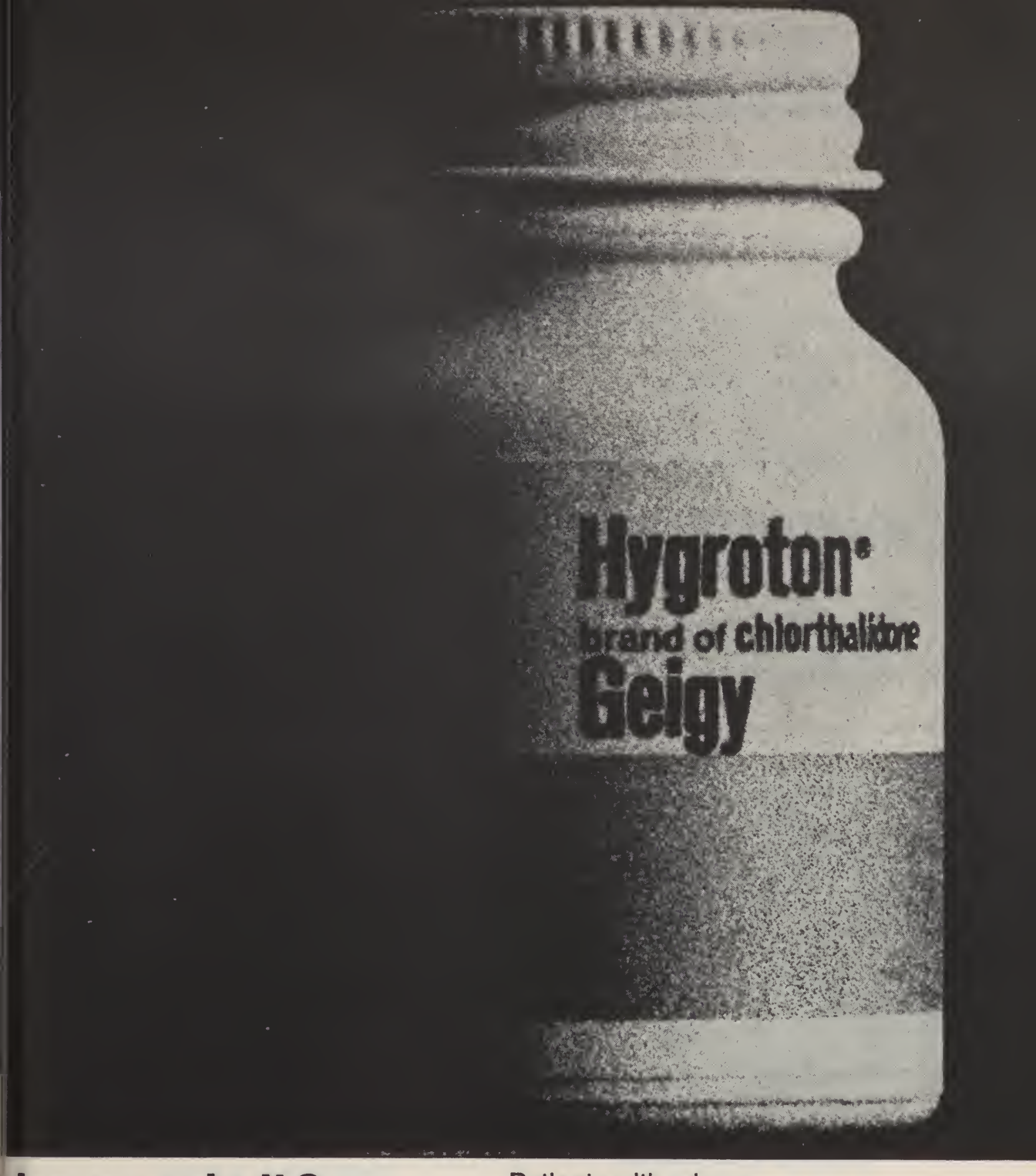
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EXECUTIVE SECRETARY'S NEWSLETTER

December, 1965

1966 DIRECTORY ISSUE

The 1966 Directory Issue of the Maryland State Medical Journal has been mailed to all Active members in the State. Additional copies are available at $2.00 per copy, plus 25¢ postage. Checks must accompany orders.

RESOLUTIONS

Resolutions for consideration at the Faculty's Annual Meeting, April, 1966, must be in the Faculty office before MARCH 1, 1966, in order to be considered. No date has been set as yet for the Reference Committee hearing.

MEDIC PROGRAMS

MEDIC programs can be heard in the Faculty building. Full details on the Educational Instruction Channel presentations may be found on pages 117 and 118 of the November issue of the Journal.

NEWS NOTES

Alfred A. Filar, Jr., M.D., has opened his office for the practice of Ophthalmology at 14 W. Mt. Vernon Place, Baltimore.

Jacob H. Conn, M.D., was elected President of the American Board of Medical Hypnosis.

W. Kenneth Mansfield, M.D., has been named President of the Medical Staff, Franklin Square Hospital, Baltimore.

New Board Diplomates of the American Society of Anesthesiologists are: Alice H. Alstatt, M.D., Silver Spring; Lee H. Cooperman, M.D., Bethesda; and John C. Devers, M.D., Bethesda.

John Krager, M.D., and Edward Hopf, M.D., have received their Master of Public Health degree from the Johns Hopkins School of Hygiene and Public Health. Both are with the Baltimore County Department of Health.

Thomas B. Turner, M.D., Johns Hopkins University School of Medicine, has been elected President of the Association of American Medical Colleges.

William Mosberg, Jr., M.D., has been elected President of the Congress of American Neurosurgeons.

A. Austin Pearre, M.D., Frederick, was honored with a Silver Service Recognition Medallion at a recent meeting of the Heart Association of Maryland.

Hans R. Wilhelmsen, D.D.S., M.D., has become associated in practice of Plastic Maxillofacial and Hand Surgery with C. Parke Scarborough, M.D.

Edward F. Lewison, M.D., has been named President of the American Cancer Society, Maryland Division.

Harry M. Murdock, M.D., has opened his office for the practice of General Psychiatry at 4 East 33rd Street, Baltimore.

H. H. Marsh, M.D., has become associated with Drs. Guerin, Kime and Sherrer in the practice of Laboratory Medicine with offices at 1010 St. Paul Street, and 6116 Belair Road, Baltimore.

Alvin P. Wenger, M.D., has removed his office to the Greater Baltimore Medical Center, Towson.

COMING NEXT MONTH

A series of articles on the history of the Baltimore City Hospitals will begin in next month's issue of the Maryland State Medical Journal. Written by Douglas G. Carroll, M.D., the history will run for approximately 12 issues. We hope that this will be the beginning of a continuing series on Maryland's medical history, and invite other papers on the distinguished men and institutions which have contributed to it. Please call the Journal office if you would like to submit an article or series of articles to this department.

John Sargeant

Executive Secretary

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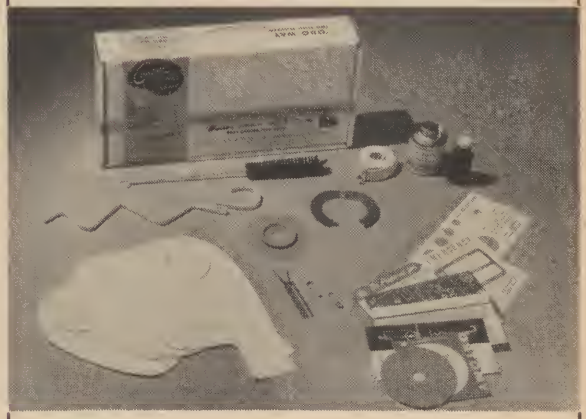
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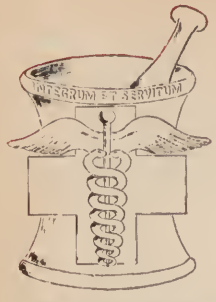
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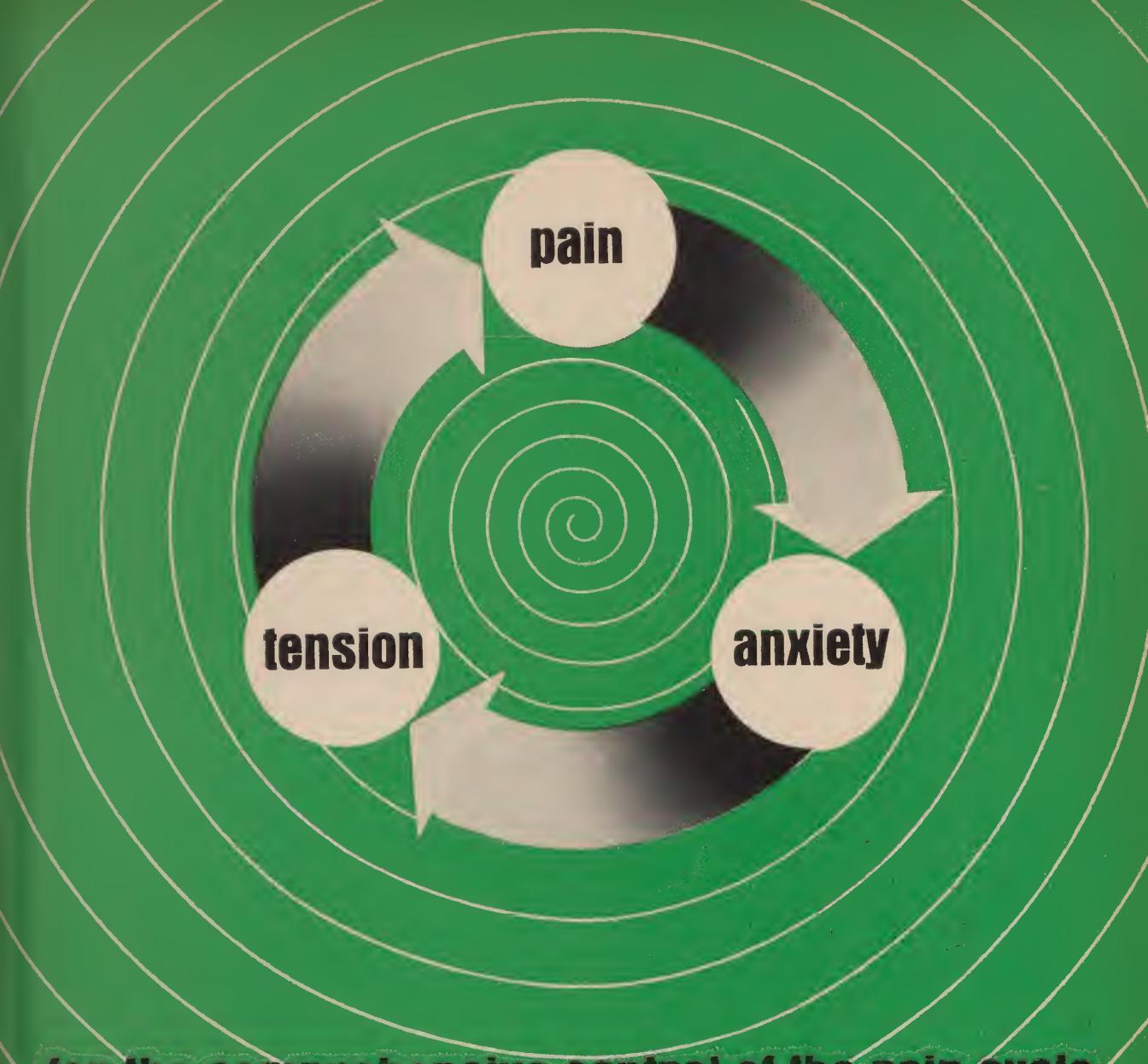
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Among the activities listed in the brochure are the following: testing for hearing impairments; loan of hearing aids, batteries, and other supplies to those unable to purchase them; rehabilitation services to teach people to use their hearing aids, to make better use of their hearing, and to supplement their ability to hear with lip reading; evaluation and remedial training for those with speech problems resulting from hearing loss, cleft palate or cleft lip, cerebral palsy, central nervous system defects, and other communication problems including stuttering, voice problems, and articulation defects; recreational activities to help those with speech and hearing problems to develop their individual talents; community education to stress the importance of preventing hearing impairments, recognizing and obtaining treatment of speech and hearing problems, and to encourage greater understanding of those with such problems.

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Dr. McKay


Dr. Everett


Dr. Dammin


Dr. Hirsch

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BUSINESS MEETINGS

CHIRURGICAL FACULTY

Donald G. McKay, MD, who will give the McCleary Fund Lecture on April 27, is Delafield Professor of pathology and chairman of the department, College of Physicians and Surgeons of Columbia University. The title of this lecture will be **Relationship of Vascular Thrombosis to Systemic Disease.** Dr. McKay was born in Sacramento, Calif., and attended the University of California, where he received his MD degree. He served an internship and was assistant pathologist at the Boston City Hospital. He has been an instructor at Tufts Medical School, Boston University School of Medicine, and Harvard Medical School. Dr. McKay was in military service for two years as chief of pathology at the US Army Hospital, Fort Belvoir, Va. He is a diplomate of the American Board of Pathology; Anatomic Pathology and Clinical Pathology.

Houston S. Everett, MD, will give the annual Hundley Lecture on **Urinary Stasis and Urinary Infection in Female Patients,** on April 27. Born in North Carolina, he is the son of a general practitioner who received his MD degree from the University of Maryland in 1897, where Dr. J. Mason Hundley, in honor of whom the Hundley Lectureship was established, was one of his instructors.

Dr. Houston Everett attended the University of North Carolina at Chapel Hill. He received his MD at The Johns Hopkins University in 1925, after which he spent five and one-half years as intern, assistant resident, and resident on the gynecological service at Hopkins Hospital, where he is now associate professor in gynecology.

During his house staff training and earlier years of practice he came under the influence and preceptorship of Dr. Guy Hunner, whom he succeeded in 1940 as gynecologist in charge of the Female Cystoscopic Clinic at Hopkins Hospital.

Dr. Everett is the author or coauthor of some 50 articles on subjects related to pathology, gynecology, and female urology. In addition, he is the author of a book, "Gynecological and Obstetrical Urology," and has contributed chapters or sections to several other books. Dr. Everett is a fellow of, and has held offices in, numerous national associations.

The Coggins Fund Lecture will be presented on April 28 by **Gustave J. Dammin, MD,** pathologist-in-chief at the Peter Bent Brigham Hospital and Elsie T. Friedman Professor of pathology at Harvard Medical School. Dr. Dammin's subject will be **Organ Transplantation: Reflections of the Host's Response and its Modification.**

Born in New York City, Dr. Dammin received his MD at Cornell University Medical College and was certified in parasitic and tropical medicine at the University of Havana. He served an internship at The Johns Hopkins Hospital and a residency at the Peter Bent Brigham Hospital. Dr. Dammin was on active duty with the U.S. Army from 1941 to 1946 and is now a colonel, MC, USAR. He is a diplomate of the National Board of Medical Examiners and the American Board of Pathology; consultant to the Surgeon General, Department of the Army and Public Health Service; consultant in pathology, Department of the Army. Dr. Dammin holds numerous other Government and honorary appointments and is a member of many national societies.

Phagocytosis and Degranulation will be the subject of the Stokes Memorial Lecture, which will be presented by **James G. Hirsch, MD,** on April 27. Dr. Hirsch, professor and senior physician of the Rockefeller Institute, has for many years studied the role of white blood cells in host resistance to infection. He and his colleagues have investigated the structure and chemical composition of various types of white cells and have discovered some of the reactions which take place within these cells to enable them to perform their functions. Dr. Hirsch earlier was associated with Rockefeller Institute in studies of tuberculosis. He demonstrated that physical activity, in place of prolonged bed rest, does not have a deleterious effect on the recovery of patients from tuberculosis who have received optimal antituberculous chemotherapy.

Dr. Hirsch is consultant to the Surgeon General and member of the Armed Forces Epidemiological Board Commission on Streptococcal and Staphylococcal Disease and Commission on Epidemiologic Survey. He is a member of many professional organizations and is a member of the Allergy and Immunology Study Section of the National Institutes of Health. Dr. Hirsch is the author of many scientific papers, serves on the editorial board of the **Journal of Experimental Medicine** and the **Journal of Bacteriology,** and is co-editor of the textbook, "Bacterial and Mycotic Infections of Man."

Born in St. Louis, Dr. Hirsch attended Yale University and received his degree in medicine from Columbia University. After an internship and an assistant residency in internal medicine at Barnes Hospital in St. Louis, he served for two years as chief of medicine at Warren Air Force Base Station Hospital in Cheyenne, Wyoming. His association with The Rockefeller Institute dates back to 1950.

Watch for further information in coming issues of the Journal



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Maryland State Medical Journal
Vol. 14, No. 12
December, 1965

Editorial

CONTROL OF VENEREAL DISEASES

The American Medical Association has launched a national educational campaign to reduce the incidence of venereal diseases. The objective of this project is to educate the public regarding the gravity of the problem, how venereal diseases are spread, how an infection may be recognized, and what the individual should do to obtain diagnosis and treatment if he suspects that he is infected.

Included in the campaign is the publication of pamphlets, posters, and radio and television spots for distribution and showing throughout the country. Announcements and editorials will appear in AMA publications. State and county medical societies, state health and educational departments, and national health agencies are being invited to participate. The Maryland State Department of Health welcomes the opportunity to cooperate with the Medical and Chirurgical Faculty of the State of Maryland and the American Medical Association in this effort to combat venereal disease.

The American Medical Association points out that the need for such a campaign is intensified by the resurgence in reported cases of syphilis and gonorrhea during the past five years.

Although an educational program is fundamental to any campaign for venereal disease control or eradication, it is inadequate unless it is supported by coordinated action which is essential to the discovery, diagnosis, and treatment of cases of these diseases.

Prompt treatment of every infectious case is the only effective way to reduce syphilis and gonorrhea to the possible point of eradication. Obviously, no case can be treated until it is discovered, and unfortunately not every infected person seeks treatment from a physician or clinic. Education may help to bring some of this backlog of untreated cases to the physician, but any which remain untreated or which are treated late will keep the infection alive in the population. The chief problem in a control campaign, therefore, is how to discover infectious cases.

JOHN H. JANNEY, MD, MPH
Chief, Division of Epidemiology
Maryland State Department of Health

The health department is the only agency which makes any attempt to discover these untreated cases and arrange for treatment by a physician or clinic. With the exception of the relatively few cases of congenital syphilis, every person with venereal disease has had sexual contact with another individual in the infectious stage—either a case of primary or secondary syphilis or acute gonorrhea. Each case is a link in a chain of infections, and each link may be the start of a new chain.

After sexual contact, an individual who suspects that he has a venereal disease usually goes to his physician or to a clinic for diagnosis and treatment. The cure of syphilis and gonorrhea is relatively simple; with one or two treatments the person is no longer infectious. Although this is an essential step in the control program, it controls the disease in only one person. The next vital step is to find all persons with whom the patient has had sexual contact, in order to break the chain of infections.

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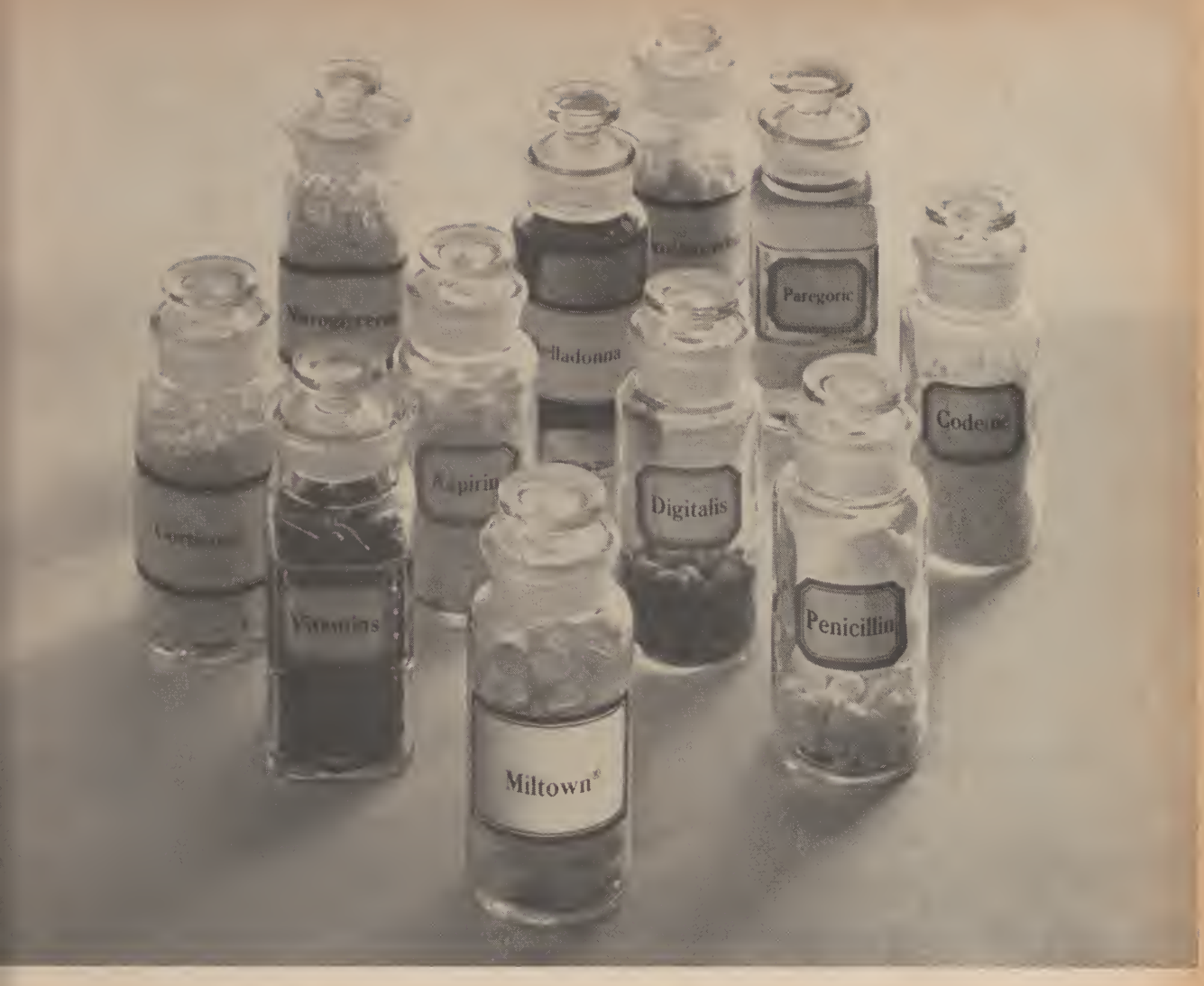
Promptly after diagnosis the case must be reported to the local or state health department. This is required of the physician by law. As soon as it is reported, steps are taken, with the physician's permission, to discover the source of the patient's infection and his sex contacts subsequent to infection. This is accomplished through an interview by a trained health department investigator. The objective of this epidemiologic investigation is to discover previously unrecognized cases, to warn sex contacts of possible infection, and to direct all contacts to a physician or clinic for diagnosis and curative or prophylactic treatment. The physician's report to the health department and the information gathered by investigators through interviews are held in strict confidence.

When the physician reports a case of venereal disease, the patient is *not* interviewed automatically. Permission must be obtained first from the patient's doctor. There are numerous instances in this state in which localized outbreaks of syphilis have been uncovered and brought under control after the report of a single case.

The epidemiological method is recognized universally as the most effective procedure in a program of venereal disease eradication. Its successful operation depends directly upon the proportion of all acute cases which are reported to the health department. Since most of these cases are treated by the private physician, it is obvious that the full cooperation of the medical profession in the matter of reporting is the keystone to the success of any program of venereal disease control. When a case is not reported, his sex contacts are unaware of their exposure and may be infected without their knowledge. Thus new foci of infection develop, and the spread goes unchecked.

Reporting of all communicable diseases is incomplete throughout the country. Maryland is no exception. A 1962 survey in this state showed that physicians were reporting less than 50% of the venereal diseases which they were treating.

The State Health Department takes this opportunity to make a strong request for the full cooperation of every physician in the state in this war on venereal diseases. If every acute case of syphilis is reported promptly to the health department, it is highly possible that the disease could be eradicated within a decade.



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

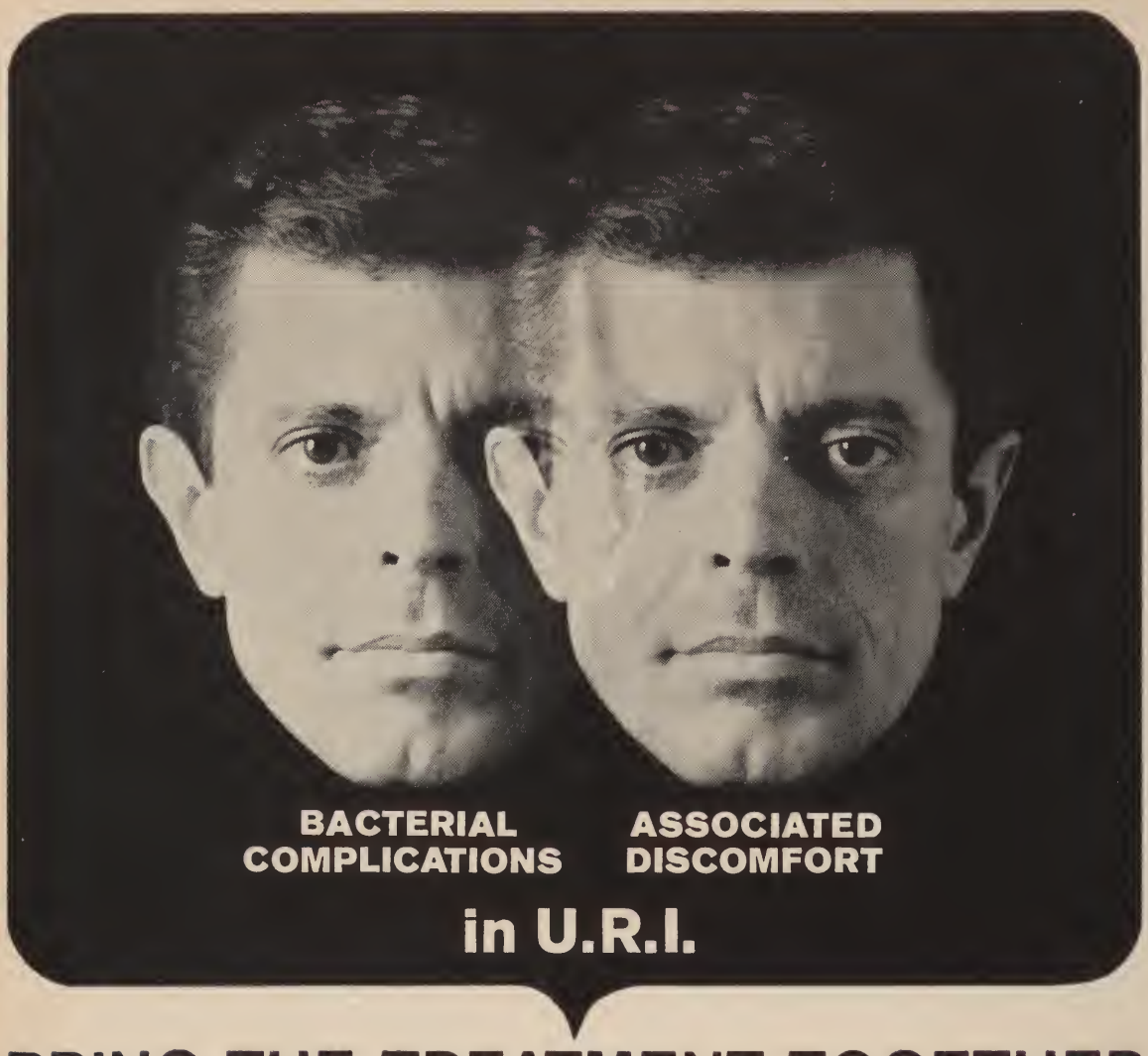
Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

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Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

HOUSE OF DELEGATES, SEPTEMBER 10*

1. Emeritus membership was granted to Ralph Cohen, MD, Montgomery County; David Brewer, MD, Washington County; Margaret B. Ballard, MD, Baltimore City; and Frank Wolbert, MD, Harford County.

2. An allocation of up to $15,000 from the educational fund was approved to institute a one-year, one time demonstration program in postgraduate education by means of a special telephone circuit.

3. The following Bylaw amendments were adopted:

ARTICLE II, Section 3

Amend Article II, Section 3, by adding to the first sentence the following: "and (3) active members of one component society of the Faculty who wish to maintain affiliation with another component society of the Faculty."

ARTICLE III, Section 1

Amend Article III, Section 1 (c) by striking out "$15.00" and inserting "$15.00 for those described in Article II, Section 3 (1) and (2)."

4. The Standing Rules of the House of Delegates were amended as follows:

1. Amend Standing Rule 2 by substituting for it the following:

2. The privileges of the floor at meetings of the House of Delegates shall be extended to members of the Faculty who are not delegates, to their guests and to such members of the staff as may be necessary. Seating on a portion of the floor shall be reserved for them at all meetings of the House of Delegates. Non-members of the House may, at the request of a delegate, be extended the privilege of debating a pending motion by a three-fourths vote. Amend Standing Rule 3 by striking out, "each member of the House on all," and inserting "any person enjoying the privileges of debate on each."

5. The report and recommendations of the Policy and Planning Committee were adopted. This report had to do with the Faculty's policy concerning the Medicare law.

6. The following resolutions were adopted:

Resolution 1/S65, recommending that the usual and customary fees be paid to private practicing physicians rendering care to hospitalized medical care program patients. Definition of the terms "usual" and "customary" was also adopted.

Resolution 2/S65, calling for legislative redefinition of civil defense to include natural disasters as well as war disasters.

Resolution 4/S65, as amended, reaffirming the Faculty's opposition to denial of membership privileges and responsibilities in component medical societies to any licensed and qualified physician because of race, color, religion, ethnic affiliation, or national origin.

(Resolution 3/S65 was ruled out of order because of conflict with the Policy and Planning Committee's report, which was adopted.)

EXECUTIVE COMMITTEE, OCTOBER 28

1. Executive Committee meeting dates for

*The minutes and reports from this meeting begin on page 60.

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1966 were adopted. A schedule of Council meeting dates for 1966 was approved for recommendation to the Council.

2. Names were selected for appointment to the Blue Cross Physicians Review Committees.

3. Approval was given to the undertaking of a review of salary ranges for Faculty personnel in 1966. A sum will be included in the 1966 budget for this study.

4. A physician who was refused assignment of benefits from Blue Shield because he is a non-participating physician questioned Blue Shield's right of such refusal. This matter ultimately was tabled, with no action to be taken pending further developments in connection with activities of the Medicare and Fee Schedule Committees.

5. The Executive Committee agreed to act as a committee of the whole to investigate any alleged violations by Maryland physicians of the 1964 Civil Rights Act, as it pertains to the Medical Care program, should the federal government report such alleged violations to the State Health Department.

6. Changes in the home and office visit fees under the Medical Care program have been included in the 1967 budget, the Health Commissioner reported, and steps are being taken to include funds for inpatient hospital care in the 1968 budget.

7. Details of the operation of the MEDIC program were approved. The Public Relations Committee's request for additional funds to add other hospitals in the network is to be referred to the House of Delegates, if considered necessary by that committee.

8. Responsibility for assisting in renegotiation of unethical contracts under Medicare was temporarily vested in the Mediation Committee.

9. Rachel K. Gundry, MD, was suggested as a replacement for Edgar P. Williamson, III, MD, on the Advisory Council on Mental Hygiene.

10. A suit instituted against the Faculty by Oswald Berrios, MD, has been dismissed. Dr. Berrios has requested certification as to membership and "moral and professional character" for licensing in another state. Appropriate certification as to membership in the Faculty will be made, subject to legal counsel's advice.

11. The Governor has advised that he has appointed a Committee on Tuberculosis Control, in line with a recent Faculty suggestion.

12. The Insurance Commissioner has been advised that the Faculty has no objection to the filing of the Eastpoint Medical Center as a nonprofit corporation, provided the subscriber is given free choice in selection of system of medical care.

13. Various proposed changes in rules and regulations of the Medical Care programs were reviewed. Of particular concern was a definition of hospital reimbursement formulas, which includes physicians' services in the hospital as part of hospital reimbursement, where local arrangements provide for such services. This might establish a precedent for further encroachment in connection with corporate practice of medicine.

14. Information concerning the Amos R. Koontz, MD, Memorial Lecture Fund is to be enclosed with the next mailing to Faculty membership.

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for control of moderate to severe hypertension

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Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



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New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week – maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.



512214

The repair of the hiatal hernia is indicated only for the relief of symptoms due to gastroesophageal reflux and the complications of esophagitis. Reflux is abolished by restoration of the sphincter mechanism at the gastroesophageal junction. This mechanism depends primarily on the role of the phrenico-esophageal ligament in maintaining lower esophageal tone. Any operative approach which includes this principle should be effective in the cure of gastroesophageal reflux.

SURGICAL TREATMENT OF HIATAL HERNIA

ELLIOTT MICHELSON, MD

Surgical treatment of hiatal hernia is employed to relieve symptoms associated with gastroesophageal reflux and not merely to repair a roentgenologically defined defect. The predominating symptom of reflux is retrosternal burning pain. Fluoroscopic observation may fail to reveal lesser volumes of gastroesophageal reflux which may, nevertheless, have clinical significance. Under these circumstances, the use of acid perfusion tests, pH meters, esophageal pressure studies, and esophagoscopy may be necessary to establish the diagnosis.

Perfusion of the esophagus with 0.1 N HCl will generally reproduce the symptoms when they are due to gastroesophageal reflux, but in the patient with achlorhydria it may be necessary to use the patient's own gastric juice to obtain a positive reaction. A pH meter placed in the esophagus 4cm above the diaphragm definitely establishes the presence of reflux when the pH of secretions is below 4. Esophageal pressure studies demonstrate the presence normally of a high pressure zone in the lower esophageal segment situated just above the diaphragm.

Hiatal hernia without reflux usually has a normal sphincter tone,[1] but in the presence of reflux the sphincter zone is absent. If a hernia is sufficiently symptomatic to require surgery, it is worthwhile confirming the cause of the complaints by objective methods.

The correction of gastroesophageal reflux presupposes a precise knowledge of normal sphincter mechanism. Five alleged factors have been

SYMPTOMS OF GASTROESOPHAGEAL REFLUX

1. Retrosternal burning pain
2. Acid taste on bending forward

DIAGNOSIS OF GASTROESOPHAGEAL REFLUX

1. X-ray
2. Acid perfusion (0.1 N HCl)
3. Esophageal manometry
4. pH meter
5. Esophagoscopy

Paper delivered before the American College of Surgeons; January 29, 1964, Baltimore.

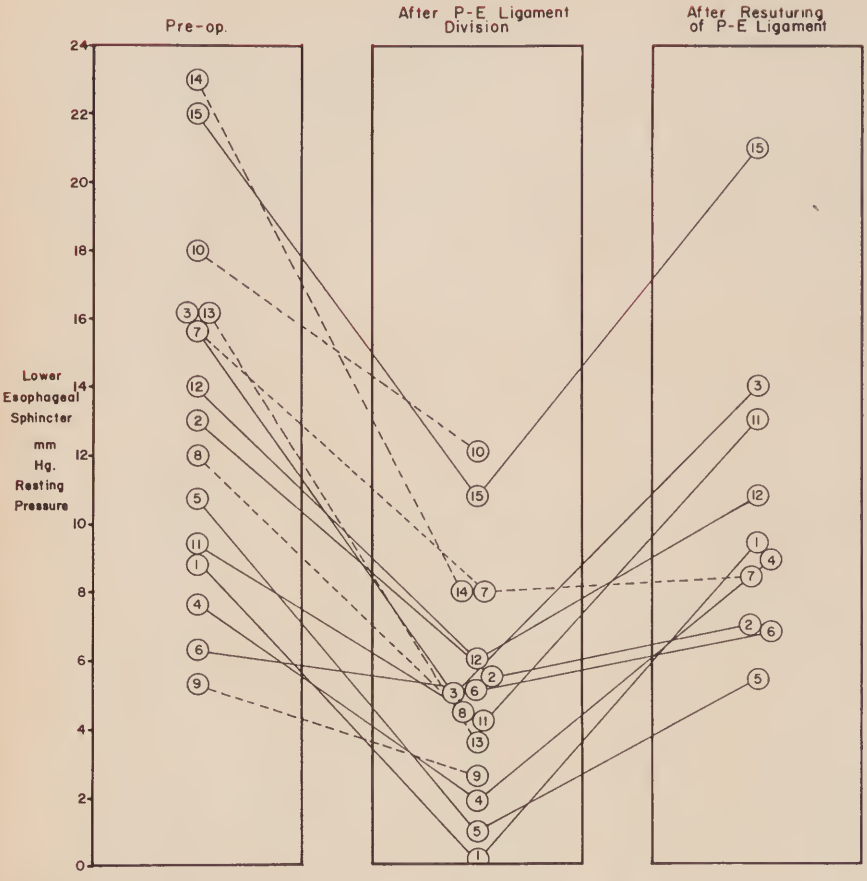


Fig. 1
Summary of manometric data before and after division of the phrenico-esophageal ligament. The solid connecting lines are drawn for the dogs in whom the entire sequence was satisfactorily completed.

thought responsible for competence of the sphincter, but none is accepted without question. Probably more than one factor is operative in maintaining sphincter competence. The crura of the diaphragm was at one time thought to be the mechanism by which reflux was prevented, but manometric studies show the sphincter zone to be above the level of the diaphragm. The presence of a mucosal rosette has been postulated, but this would not explain the 2-3 cm segment of increased pressure in the lower esophageal segment. An intra-abdominal segment of the esophagus has been thought to act as a valve preventing reflux, but it is questionable whether this segment is at all present. The phrenico-esophageal ligament is now recognized as a major factor in maintaining the lower esophageal sphincter tone. The oblique fibers of the loop of Willis surround the cardia of the stomach and by preserving the oblique entrance of the esophagus into the stomach, may act as a barrier to reflux.

FACTORS IN GASTROESOPHAGEAL SPHINCTER COMPETENCE

1. Phrenico-esophageal ligament (intrinsic sphincter?)
2. Oblique fibers — loop of Willis (oblique insertion of esophagus into stomach?)
3. Crura of diaphragm(?)
4. Mucosal rosette or valve
5. Intra-abdominal esophageal segment

In order to establish the role of the phrenico-esophageal ligament, Dr. Charles I. Siegel and I performed a series of studies on 15 dogs.[2] After establishing the presence of a zone of pressure, approximately 14cm H_2O in the lower esophageal segment, we cut the phrenico-esophageal ligament. The sphincter pressure decreased to an average of 4cm; after repair of the ligament, the pressure rose to an average of 12cm (fig 1). We concluded that the phrenico-esophageal ligament helped to maintain the sphincter tone in the low-

er esophagus. We operated on one dog who was found to have a low pressure zone and found a hiatal hernia. After repair of the phrenico-esophageal ligament the pressure returned to normal.

Not all cases of reflux with and without hiatal hernia need be corrected by surgery. The infant who spits and vomits his feedings because of reflux and esophagitis will, in most cases, be cured of his chalasia by being fed in the sitting position. The pregnant woman with substernal burning may have a hiatal hernia, but the physiologic removal of the tumor brings about a cure. The young man with tight abdominal muscles who suddenly takes on a large amount of weight may develop reflux. In the course of time his abdominal muscles relax and symptoms may disappear. Operation is indicated for the patient whose persistent symptoms defy medical treatment or who has developed complications from his esophagitis with bleeding or stenosis.

The choice of repairing a hiatal hernia with reflux through the abdomen or through the chest should depend not upon the surgeon's familiarity with the respective area but rather upon the associated esophageal or abdominal disease. The abdominal approach is necessary when the reflux is primarily due to pyloric obstruction or when a duodenal ulcer is present. In the presence of stricture or short esophagus, the thoracic approach is recommended.

Procedures which do not directly relieve the reflux but only indirectly change the character of the gastric juice or the emptying of the stomach cannot be considered physiologic. Vagotomy, by decreasing gastric emptying, will increase the possibility of gastroesophageal reflux; for this reason, anticholinergic drugs are not given in the medical treatment of reflux esophagitis. The use of pylorotomy or other surgical methods increasing gastric outflow is necessary when vagotomy is performed but should not be considered the prime method of treating esophageal reflux.

Transthoracic repair of hiatal hernias with reflux is my preference. The thoracic approach permits careful examination of the lower esophageal segment, meticulous release of the esophagus from mediastinal fibrosis, peroral forceful dilatation of stricture if necessary, and precise suture of the phrenico-esophageal ligament.

Injection of the intercostal nerves before and after retraction of the rib cage with lidocaine (Xylocaine) prevents subsequent postoperative pain. Opening the mediastinal pleura frees the esophagus sufficiently cephalad to allow easy taxis downward. In the presence of a stricture, the strictured area is encircled by the hand as the dilator is forcibly passed down the esophagus by the anesthetist. The right and left crura are cleared of surrounding adventitia in preparation for careful closure posterior to the esophagus. A small opening is made in the diaphragm 2cm above the esophageal hiatus and a finger inserted through the opening, curved back through the hiatus, places the phrenico-esophageal ligament on stretch. A suture is taken through the ligament close to the esophageal wall in order to encompass the dense collagenous and elastic fibers of the ligament. The ligament is then cut free from the diaphragm. Approximately four sutures are placed through the ligament stump, the last suture being close to the left vagus nerve and should include some of the oblique fibers of the loop of Willis. Sutures are passed through the hiatus then back through the diaphragm and tied on the thoracic surface.

No attachment of the fundus to the diaphragm is necessary unless the ligament is thought to be markedly atrophic. In this case, several sutures are taken through the oblique fibers and the medial aspect of the fundus is sutured to the left lateral wall of the esophagus. When further exposure is necessary to explore the abdomen, the diaphragm is opened circumferentially leaving a cuff of tissue at least 2cm long on the coastal wall to facilitate closure. By retracting the diaphragmatic edges, the entire stomach, spleen, duodenum, and left lobe of the liver can be easily and completely investigated.

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Baltimore, Md. 21217

GENERIC AND TRADE NAMES OF DRUGS

Lidocaine—*Xylocaine*

REFERENCES

1. Atkinson, M., et al: Esophago-gastric Sphincter in Hiatus Hernia. *Lancet* 2:1138, 1957.
2. Michelson, E., and Siegel, C. I.: The Role of the Phrenico-Esophageal Ligament in the Lower Esophageal Sphincter. *Surg Gynec Obstet* 118:1291-4, 1964.

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Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

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TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
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EVALUATION OF PSYCHIATRIC DISABILITY

In evaluating disability, the phychiatrist may be helpful, of no assistance, or contrary to the legal and judicial process. Some reasons for this are to be found in differences of responsibility between doctor and lawyer, others in the nature of psychiatry, and some in difficulties of diagnosis. The last includes consideration of what the patient gives as history as well as the patient's motivations. The auhor illustrates these points with his personal experiences and thoughts and speculates on possible alterations.

LEONARD J. GALLANT, MD
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THE GREEKS EVOLVED A SYSTEM of medical psychological understanding in which various organs of the body produced substances that regulated feelings. For example, a sudden flow of bile to the brain might bring on madness. Our words of today, *bilious* and *melancholic,* reflect this belief. The seat of the soul was in the heart, and some placed the mind in the diaphragm.

Hippocrates, who died in the fourth century, BC, is considered the first to place the brain as an important organ for psychological functioning. He did not make this as specific and clear as it is known today, nor did he ascribe to it independent, inherent psychological qualities. He thought that breath (air) was the source of intelligence and feeling. He thought that the air reached the brain through the mouth and then became distributed to all parts of the body.

Today we are involved in the reverse: expelling our breath through our mouths, forming words, and hoping to convey as much helpful meaning as possible. My purpose is to share with you some personal experiences and thoughts about what psychiatrists may offer to the legal and judicial process. The nature of the dynamic psychiatrist must be stated immediately, namely, he hopes that he gets his answers from observations and experience. Thus, I look upon today as a two-way street where I may also learn.

Twenty years ago, while in psychiatric training in the midwest, I was subpoenaed for the first time as an expert witness. The case was that of an elderly gentleman who had been a patient in the hospital under my care. He had changed his will in favor of a recently acquired girlfriend. The family objected and the will was contested. As I sat on the witness stand, I became more and more anxious. Under cross-examination, a well-informed and skillful attorney began to question me on the aging process,

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the effects of this on the brain, and eventually on mentality and judgment. I liked my patient and began to feel that I was defending him as well as myself from embarrassment. My inexperience and naivete showed glaringly. The moment of truth came with a dramatic flourish when the attorney pointedly asked me if I thought that the patient's brain had softened and become smaller as a result of age. Loudly and firmly, I blurted out that there was absolutely no doubt that the gentleman's brain was the same size and shape as everyone's brain. In fact, I declared that all adult brains were of the same size, shape, and weight at any age. As I heard myself utter these profound wisdoms, I was aware of how frightened I was, how inaccurate my comments were; but strangely enough, my outburst settled the court down, stopped my inquisitor from bothering me, and for all I know may have had some ultimate effect upon the decision of the court, which was to uphold the man's altered will as legal and binding.

Now, in retrospect, I wonder if at that moment, by reason of emotional duress, I might have been considered temporarily disabled, and if so, my disability was accepted as evidence in the court.

This experience served many useful purposes for me, including that of making me aware of both the same and the different directions that medicine and law take in their effort to help people. The law is interested in intent, in the behavior of the individual, and in the consequences of that behavior. It is also interested in the settlement of grievances. The judicial process evaluates and judges the motivations of a person. The psychiatrist is interested in understanding what this motivation is about, at times in an effort to alter the course of events for the individual, aiming toward better health. His commitment is one of medical responsibility to his patient. He is bound to the Hippocratic oath, stated centuries before the English Common Law began. As a result, he may find himself at odds with the legal process at times.

Mental, emotional, psychological, or nervous disability has been defined in many ways. In attempting to find some common denominators, one struggles with differentiating between reasoning and feeling as well as the need to separate eccentricity from insanity. Further, in evaluating disability, how does one measure justifiable anxiety against malingering? How far does mental illness develop before detectable alteration in thinking and judgment occurs? Would not all these issues be smoothly settled if we had a simple system of physiology like the ancient Greeks?

The story is told of the man who had a flat tire just outside the fence of a state mental hospital. He jacked up his car, took off the hub cap, unscrewed the lug bolts, and carefully put each lug bolt in the hub cap beside him. As he had the wheel off and was about to put the spare on, a car came by, drove very close, and hit the edge of the hub cap. The lug bolts were thrown out over the road and all of them rolled down a storm drain. He couldn't recover them. There he was with his spare tire but no way to hold it onto the hub. He scratched his head awhile and stood around trying to figure this situation out when someone on the other side of the fence said, "Look, why don't you take off the other three hub caps and take a lug bolt off each wheel. Then put your wheel on with those three bolts. That will hold you until you are able to get some more lug bolts." While he was doing this he began to think, "What kind of a situation is this where a patient in a mental hospital tells me how to solve a very simple problem—now that he has told me—though before it was so difficult." So when he finished, he went over to the fence and said, "Why in the world are you here? You're smart. You could tell me to do something that I couldn't figure out myself, and I'm not in a hospital like this."

"Oh," the man said, "don't be so surprised. I'm not here because I'm stupid, I'm here because I had a nervous breakdown."

After weeks of pondering and discussing with colleagues, I have come up with the following: A psychiatric disability may be defined as a degree of difficulty or impairment in functioning of an individual in mental, emotional, or psychological affairs with consideration to: 1) the individual's prior level of ability, and 2) the average or normal behavior of people at any given time in any given culture. This impairment may be caused by physical, physiological, or psychological alterations or a combination thereof.

A brief case report at this point might illustrate other aspects of the paradox existing between medical psychology and the law. A laborer was struck in the chest by a heavy metal

frame. The skin and some of the superficial tissues were partially cut through. When the man was in the hospital, an electrocardiogram was done because of complaint of chest pains. It was learned later that the electrocardiogram had technical inaccuracies as a result of being taken over the bandages. It was interpreted as abnormal. A large focus of interest on this man's cardiac status was made. As a result, elaborate tests were performed, and the man became conscious of his heart as a spot of interest to the medical profession. When the case came to Workmen's Compensation it was a focus of interest for the legal profession. Because he seemed depressed, the patient was sent to the psychiatrist, who seemed reasonably certain that the man had been suffering from the mental illness of schizophrenia for years. In spite of this, he had been able to maintain himself with some degree of self-respect in society by hard work. It seemed clear that the man suffered from this mental illness before the accident and that what had appeared to be depression was a combination of many factors after the accident, factors such as worry about his heart. This was made even more dramatic because he reported that his father had had heart disease. Also, there was the nebulous factor that is so difficult to evaluate, namely, the potential gains from legal settlement. The case eventually went to a court of appeals, where the man was awarded total permanent disability. The psychiatrist diagnosed this patient as suffering from a schizophrenic illness. Because of the history and past performance, a strong recommendation was made that he return to work as soon as possible, since further checking of the electrocardiogram showed no heart disease and the original interpretation probably wrong. Yet, on the other hand, the disability could not be denied in terms of the man's reaction not only to the injury but to the attention of the medical and legal profession. I have no follow-up on this man, but if I were to concern myself with his medical welfare I would have to press for him to return to work. This opinion is not intended to deny his claim for disability.

In general, one may say that the psychiatrist as a physician has the responsibility for the health of the individual; but he must acknowledge the bias placed upon him as a result of being retained and paid by either side. It might be said that the attorney's responsibility is the pursuit of truth as established by facts. In reality, though, he is an advocate for unilateral assistance to his client to effect a settlement of differences. Thus, he may share with the doctor difficulties in deciding what is best for the individual.

In my experience, a psychiatrist is more often consulted when the cases are confusing and troublesome. A recent example concerned a patient who was always quarrelsome and difficult with doctors. It was hoped that some psychiatric problem could be found which might then detract from his claim for injury. Instead, an organic illness of the central nervous system was diagnosed that probably existed prior to the alleged head injury. In another situation, a plaintiff's attorney called upon me because of a patient's prior psychiatric treatment. It was feared that this might negate a claim for disability. It did not.

The psychiatrist was asked by an insurance company to examine a person involved in an automobile accident. It was thought that the patient was fabricating bizarre symptoms. Instead, brain damage seemed the only logical diagnosis. However, this was not detected by the doctors for the plaintiff. Referring to my previous point, here again a dilemma presents itself, namely, medical responsibility toward the patient and the economic responsibility encumbered by agreeing to work for either plaintiff or defendant. However, it does point to one practical function the psychiatrist can perform. He may be able to distinguish between organic and non-organic consequences of presumed head injury. When it appears non-organic, the case becomes sticky, since the psychiatrist must go on observations and acquired history.

The limitations of the psychiatrist are many. He has fewer specific guide lines than those available to his medical colleagues, such as the x-ray to the orthopedic physician. When confronted, he must declare honestly that diagnosis and evaluation are the results and combinations of years of experience, observation, training, and his own personality. The psychiatrist may call upon the ancillary fields of psychology and electroencephalography, to mention two. But here again, the standards for measuring disability are few. It would be desirable if there could be more; and perhaps as there are more, this field will become clearer. Research continues in neurophysiology. Perhaps some of this fantastic and fascinating material will some day help to provide

better yardsticks. For example, instruments are so fine that it is now possible to measure ions of material and their effect upon single nerve cells. Also, by combining computers and instruments like the electroencephalogram, an individual can be tested on reading material to determine if he does or does not understand it no matter what he consciously states.

From the standpoint of the attorney, it is well to understand that psychiatrists vary considerably, depending upon their training and convictions. As a result, there may be little consistency among psychiatrists of different persuasions. Yet, I feel that this may not be utilized sufficiently by the legal profession. I suspect that few if any psychiatrists with good intensive, dynamic or psychoanalytic training, or both, become involved in medico-legal work. Partly this may be because the psychiatrist has more difficulty in rearranging a schedule to suit the needs of lawyers and courts than some of his medical colleagues; partly also because of the symbolic meaning the psychiatrist has. Some aspects of this may be mentioned. First, the psychiatrist is accustomed to having hostility aimed at him. When it comes from many directions, as in a court room, it is more difficult than when it comes from only one person, such as in a treatment relationship. Secondly, if properly trained, the psychiatrist has some degree of knowledge of the unconscious and how it works. He also may represent the unconscious and thereby the unknown, the forbidden, and the frightening. This makes him a threat by his simple presence. Oversimplified, the unconscious is that part of mental and emotional life buried under the surface, like the bottom part of an iceberg. This goes on beyond awareness. When on the witness stand, I have a habit of asking the attorney to repeat or restate his questions. My conscious intent is to ask for clarity. At times I am aware that this is a hostile maneuver on my part, and it can provoke antagonistic feelings in the attorney.

One may observe unconscious factors affecting the outcome of a case. Appearing for the plaintiff, I examined a young woman hit head-on in an automobile accident. Circumstances were such that she could not avoid the collision. She had some degree of actual orthopedic and neurologic damage to her arm; she also had a high degree of whimpering anxiety. This woman had the capacity to annoy and irritate people. During the trial, she sat with her arm in a sling and went through grimaces, tears, and anxiety. I was aware that her discomfort spread to the jury. Although she won a verdict, the settlement was but a small fraction of what she had claimed and covered a small part of her medical expenses. What seemed to be happening was that this woman gave the picture of the underdog to whom all are considered to be sympathetic. The added feature was severe unconscious masochistic problems, or a pathologic need to be miserable and be punished, which made others so uncomfortable that the sympathy was neutralized by disdain. In other words, she portrayed the repulsive and thereby disliked underdog.

One of the difficult questions raised in court, from the psychiatric standpoint, is: What is the percentage of disability? Personally, I think this can be stated only as opinion. I wonder whether it would be better for the psychiatrist to present his observations and let the percentage and degree of disability be decided in court as part of the judicial process. At any rate, in psychiatric disability, even when only opinion, percentage of disability is best stated after enough time has elapsed for sound clinical judgment.

Two intriguing points deserve brief mention. I believe that the observations of a well-trained and competent psychiatrist comprise an accurate medical tool. This is difficult to prove.

Secondly, in determining the history, all doctors, and perhaps more so the psychiatrist, rely to varying degrees on what the patient says. Thus when medical history is offered in evidence, is it hearsay? Perhaps this issue is more theoretical than practical; but it may have something to do with the resistance of courts and lawyers, and confusion or annoyance to doctors, in such as the following. A person is involved in an accident and claims resultant anxieties. No physical or other direct evidence exists for the suffering than the person's word. Often this suffering stops immediately upon settlement. Does this make the suffering less real? Is this hearsay evidence? Is the person a malingerer?*

*The Honorable W. Albert Menchine, judge of the Circuit Court for Baltimore County, as moderator, elaborated and clarified this issue as follows:

a) Wilhelm vs State Traffic Commission—230 Maryland, page 91-97: ". . . a non-treating physician may not relate the history given to him by a litigant."

My personal views about evaluating psychiatric disability can be expressed in three ways:

First, the psychiatrist as a physician should make every effort to present and clarify normal and abnormal mental and emotional functions for his colleagues. Although under current practice he is biased, the psychiatrist must try to avoid judging.

Second, by sharing a fantasy of mine with you, I do not intend to try to tell anyone how to run his business. I wonder whether or not a system could be devised to set up a panel of doctors and lawyers for the creation of an impartial board for the review of accident cases. This could be presented in summary to the court; or it could settle some medicolegal cases by itself and reduce the pressure on the court calendar. This is not to be construed as a suggestion to replace any part of the legal or judicial process.

Finally, if one has a flair for the imaginative, I might describe some but not all of medicolegal work as pertains to the psychiatrist as a dance. One party is doing a Viennese waltz, one party is doing the twist, and the music in the background is a John Phillip Sousa march. The psychiatrist might stop doing the waltz, the attorney might stop doing the twist, and both together learn how to march in society.

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In this circumstance, this would be considered hearsay evidence. Such material can be admitted only if it is framed in hypothetical questions or if the doctor sits in court and hears all the evidence.

b) Yellow Cab Co. vs Hicks—224 Maryland, page 563: In this case, an orthopedic surgeon served as consultant. This was for the plaintiff. The testimony was ruled admissible because the doctor made recommendations for the treatment of the patient as well as evaluating him.

The legal theory is that if a doctor is treating a person, it is presumed that what the patient tells him is the truth, since such statements influence the doctor's treatment. On the other hand, the doctor who examines solely for the purpose of testifying may get inaccurate and misleading information from the patient.

REFERENCES

1. Ludes, F. J., and Gilbert, H. J.: *Corpus Juris Secondum,* American Lawbook Co., Revised 1963, vol. 26A, page 963.
2. Novey, S.: The Meaning of History in Psychiatry and Psychoanalysis, *Brit J Med Psychol* 35:263, 1962.
3. Noyes, A. P., and Kolb, L. C.: *Modern Clinical Psychiatry,* ed 5, W. B. Saunders Co., Chapter XXXVIII, 1958.
4. Overholser, W.: Major Principles of Forensic Psychiatry, *American Handbook of Psychiatry,* Silvano Arieti, Volume II, Chapter 95, 1959.
5. Zilboorg, G., in collaboration with Henry, G. W.: *A History of Medical Psychology,* W. W. Norton & Co., Inc., 1941.



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The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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R. ROBINSON BAKER, MD, STEWART LOTT, MD, JERRIE CHERRY, MD, JOHN HOOPES, MD

A recent report by the End Results Group of the National Cancer Institute has summarized the incidence of various types of malignant disease within this anatomical area. The following discussion is largely based on this report.

A total of 5,552 malignant lesions of the skin was reported between 1950 and 1954. Basal cell carcinomas were the most common lesions, followed by squamous cell tumors and malignant melanomas.

The buccal cavity and pharynx were the site of origin of 5,985 malignant tumors. These lesions accounted for approximately 10% of all malignant tumors seen in males and 3% of all cancers in females. The lip was the most common site of origin, followed by the tongue, salivary glands, mouth, and pharynx. Most of these lesions were squamous cell carcinomas arising from the mucous membrane. Adenocarcinomas are encountered occasionally in the salivary glands.

A total of 338 tumors was reported arising from the nose, nasal cavity, middle ear, and accessory sinuses. Malignant tumors in this area arise either from the mucosal lining (squamous cell carcinoma) or the mucous glands (adenocarcinoma). Squamous cell carcinomas are approximately three times more common than adenocarcinomas. Most of these lesions arise from the maxillary antrum, nasal cavity, or ethmoid sinuses. Tumors of the middle ear, sphenoid, and frontal sinuses constitute less than 10% of these lesions.

The End Result Report contained 13,052 cases of laryngeal carcinoma, 75% of which were located on the vocal cords. The superglottic portion of the larynx is the next most common site of origin, followed by the infraglottic portion of the larynx. These laryngeal tumors are virtually all squamous cell carcinomas.

There is considerable variation on the prognosis of these tumors. Prognosis depends upon:

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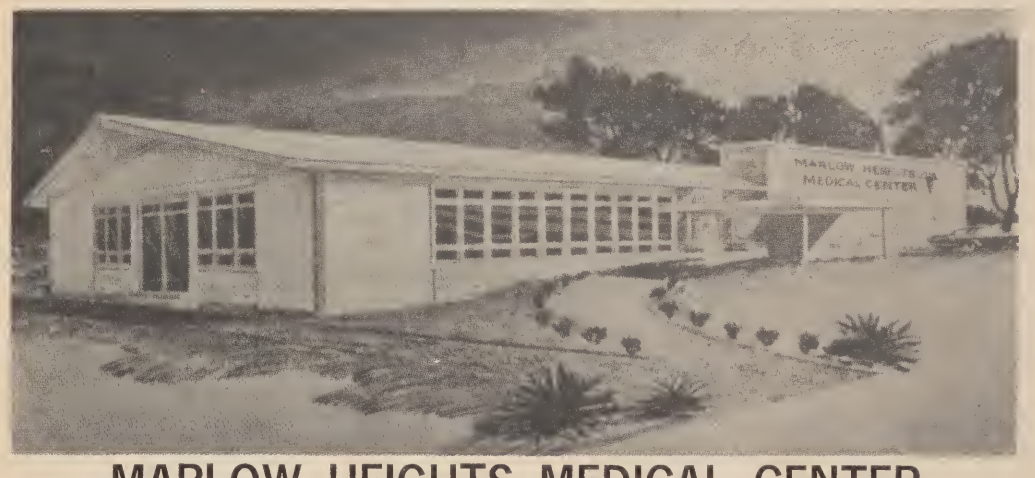
1) the anatomic location of the tumor; 2) the size of the lesion on initial examination; 3) the presence or absence of palpable cervical lymph nodes; and 4) the degree of histologic differentiation. Skin lesions carry the best overall prognosis, followed by the larynx, buccal cavity, nose, and accessory sinuses. The survival rates correlated with the stage of the disease are summarized in the table.

Intelligent management of these patients requires a thorough knowledge of the many diagnostic, therapeutic, and reconstructive techniques related to the fields of general surgery, otolaryngology, radiotherapy, and plastic surgery. The cooperative effort of a number of highly trained specialists helps to assure that the patient receives optimal care. Diagnostic workup and decisions as to the method of treatment and follow-up care should be made by joint and continuing consultation between representatives of these specialties. This is best accomplished through a conjoint tumor clinic for both private and ward cases. This approach should appreciably increase the salvage rate of patients with malignant disease in area of the head and neck.[1]

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REFERENCE

1. End Result in Cancer, Report No. 2, 1964. Public Health Service Publication No. 1149, U. S. Department of Health, Education, and Welfare.



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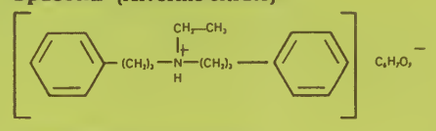


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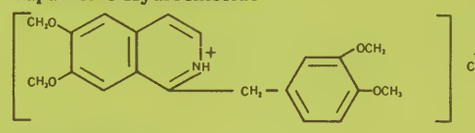
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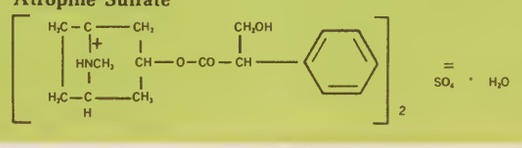
Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate



the interesting results *in vitro* and *in vivo* with NON-NARCOTIC SPACOLIN™ 120 mg. tablets

(Alverine citrate)

the potent musculotropic counter-spasmodic 2½-3 times stronger than papaverine

IN LABORATORY

Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5°C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1/150 that of atropine sulfate.







IN MAN

Double-Blind Study of a Spasmolytic Compound[1]

By ITALO EVANGELISTA, M.D.

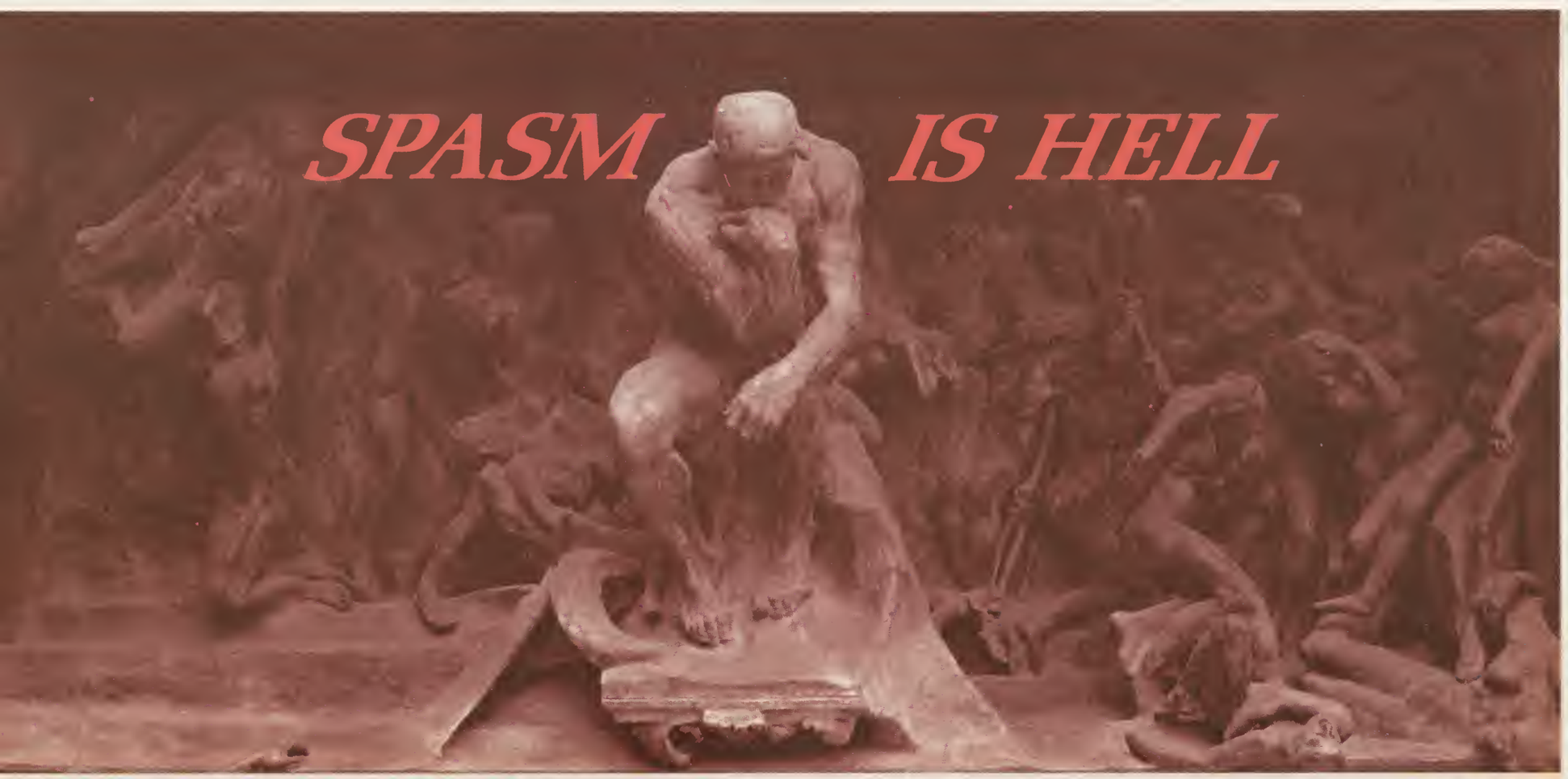
Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts; Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

***Excellent** — complete relief of symptoms during therapy.
Good — definite relief but still aware of symptoms periodically.
Fair — symptoms reduced in intensity but still present.
Poor — little or no therapeutic benefit.

". . . a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

(1) To be published



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NON-NARCOTIC



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Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) ..... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examina-

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets 1/2 hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle de-

PHILIPS ROXANE LABORATORIES

THE ASSOCIATE DEGREE PROGRAM IN NURSING

ANN KLINGELHOFER, RN
Director of Nursing Education
Baltimore Junior College

In September, 1965, the first students began the associate degree program in nursing at the Baltimore Junior College and the Catonsville Community College. Although new to Maryland, the first such programs were established in the United States 13 years ago. Since that time, there has been a steady growth in the number of graduates and programs. From more than 100 located in the junior or community colleges, there were 1,962 graduates in 1963-64.[1]

These programs did not suddenly appear but were the result of a thoughtfully planned and carefully executed experiment—The Cooperative Research Project in Junior and Community College Education for Nursing, conducted at Teachers College, Columbia University, under the direction of Dr. Mildred L. Montag. The philosophy of the project was based on a broad spectrum of nursing activities with the professional or complex functions placed at one end and the simple or assisting functions at the other end. In the center were those activities considered technical, requiring some judgment and skill, and relating directly to the care of patients. The latter group pertains to the associate degree program. The graduates are able to function as described in *Nursing Education Programs Today*[2]:

> (They) are prepared to give care to patients as beginning general duty nurses, drawing upon their scientific knowledge and understanding of human behavior and needs. They are prepared to develop satisfactory relationships with people, to cooperate and share responsibility for their patients' welfare with other members of the nursing and health staff, and to be self-directive in learning from experience as practicing nurses.

More specifically, Dr. Montag, speaking at a meeting of the Association of Military Surgeons

An associate degree program in nursing is being offered at the Baltimore Junior College and the Catonsville Community College. The program is patient-centered throughout, and clinical experience is correlated with the course content.

in 1964, defined the graduates' role as being able to give direct care to patients as a member of a nursing team. They should be able to assist in the planning of nursing care, to make patients comfortable, to observe and report changes in the patients' conditions, to recognize basic human needs, and to evaluate the nursing plan's effectiveness. The description is not too different from the concept of the nurses or the type of nursing expected by many doctors and patients. Nursing and nurses have been criticized for their apparent lack of concern for patients; the content of the associate degree program is patient-centered throughout.

A shortened program is not new to nursing:

> The requirements of the U.S. Cadet Nurse Corps during World War II that all essential theory and practice had to be completed in thirty months caused many schools to realize they could give the same instruction they had been giving in three years in a shorter period. In fact, it has brought some real questions as to the desirable length of the program in the minds of many.[3]

The associate degree program is not a reduced diploma program nor is it the first two years of a baccalaureate program. It is entirely new, offered within an educational institution for two years, four semesters. There are certain advantages for nursing to be under the auspices of colleges:

1. The program is controlled by the college and is educationally centered without any service needs to be considered.
2. Approximately one-half of the student's program is in general education similar to other technical programs.
3. There is less repetitive work with resultant time reduction.
4. There is low cost to the student who can live at home.
5. The student can participate in college campus life with students in other areas.

Further, the graduates are prepared to take the Maryland State Board of Nursing examination.

The nursing courses present a sequence of learning experiences from the simple nursing functions to those requiring skill and some judgment, the normal to the abnormal, and the familiar to the new. The courses presuppose a foundation in the fundamental sciences upon which nursing practice is based.

How can the mass of nursing knowledge be compressed and remain comprehensive? The nursing courses encompass broad areas: elements of nursing practice; care of the mother, newborn, and child; and care of the mentally and physically ill. The content is organized to bring like experiences together so that learning is enhanced.

One method of organization is according to guiding principles, which are patient-centered, such as those presented by Fuerst and Wolff[4]: 1) maintaining the individuality of man, 2) maintaining physiologic functioning during illness, and 3) protecting the patient from external factors causing illness. For example, in teaching the care of patients with fluid and electrolyte imbalance, scientific principles are considered along with specific disease entities which cause the imbalance. The commonality or physiologic principle is the imbalance. Further delineation is how the nurse's intervention assists the patient. How is the patient helped by the presence of the nurse? How can the nurse help the patient to cope with his feelings about his disease? How can the nurse protect the patient from other diseases or injury? Obviously, great responsibility for learning is placed upon the instructor and student.

The clinical experience is correlated with the course content. This begins the first semester of the first year and is continued each semester of the two year course. Health agencies are selected on the basis of the experiences needed to attain the course objectives. The Johns Hopkins Hospital provides clinical experience for the students from the Baltimore Junior College, and the Bon Secours Hospital is the clinical area for the Catonsville Community College students.

To return to the above example, the instructor, who is a member of the junior college faculty, needs latitude to select patients demonstrating fluid and electrolyte imbalance for student experience. The instructor may devote up to two or three hours in the hospital before the day of experience for patient assignment. The students and instructor have a conference at the hospital to discuss the assignment both before and after the experience. Much teaching is done at the patient's side, and discussion at the post-experience conference benefits all students as they analyze their reports and share their new knowledge. The assignments are patient-centered with emphasis on the nursing intervention which meets the basic needs of patients within the framework of the plan of treatment set by the doctor.

The nursing education courses are now being taught similarly in many of the diploma and baccalaureate programs, the main difference being in the amount of time available for experience and teaching. Ruth Sleeper[5] said "That the graduates of the junior college . . . program(s) on first employment need more time to develop skill in nursing technics and in the application of their knowledge is to be expected." Consequently, the employers have had to provide some supervised experience and well-defined orientation programs during the graduates' first employment.

One of the great benefits of the program is that men and women are attracted from the community, are educated in the community, and remain there for employment.[6]

Most of the graduates hold positions as general duty nurses.[7] Those who hold beginning leadership positions have secured appropriate academic preparation.[8] Although the program is considered terminal, the individual may continue in an educational institution. Certain courses may be applied toward more advanced study; however, this is not at the present time considered part of an escalation procedure for nursing education.

These programs do not purport to replace any other type of nursing education but to contribute more nurses for employment in health agencies. If the educational program is sound, competent graduates will result. If the work environment perpetuates the type of situation in which the graduate has been educated, and if the graduate is able to function as taught, the program will have fulfilled its purpose and with it, the personalized care desired during illness.

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REFERENCES

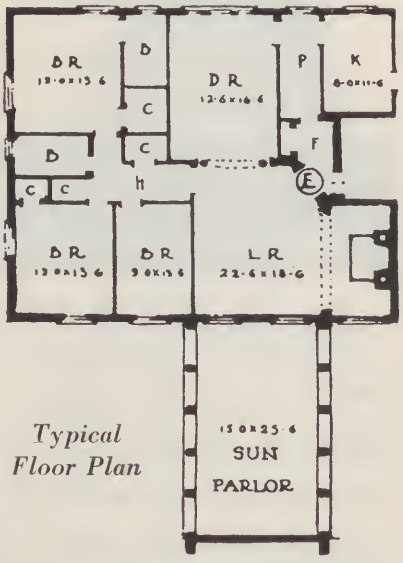
1. *Facts About Nursing,* New York: American Nurses Association, 1965, p88.
2. *Nursing Education Programs Today,* New York: National League for Nursing, 1961, p11.
3. Montag, M.L.: *The Education of Nursing Technicians,* New York: G. P. Putnam's Sons, 1951, p45.
4. Fuerst, E. V., and Wolff, L.: *Teaching Fundamentals of Nursing,* Philadelphia: J. B. Lippincott Co., 1963, p129.
5. Sleeper, R.: Nursing Education in Evolution, *New Eng J Med* 271:27-30, 1964.
6. Montag, M. L.: *Community College Education for Nursing,* New York: McGraw Hill Book Co., 1959, p182.
7. *Report on Associate Degree Programs in Nursing,* New York: National League for Nursing, 1961, p29.
8. *Ibid.* p32.

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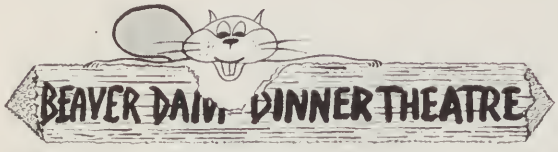


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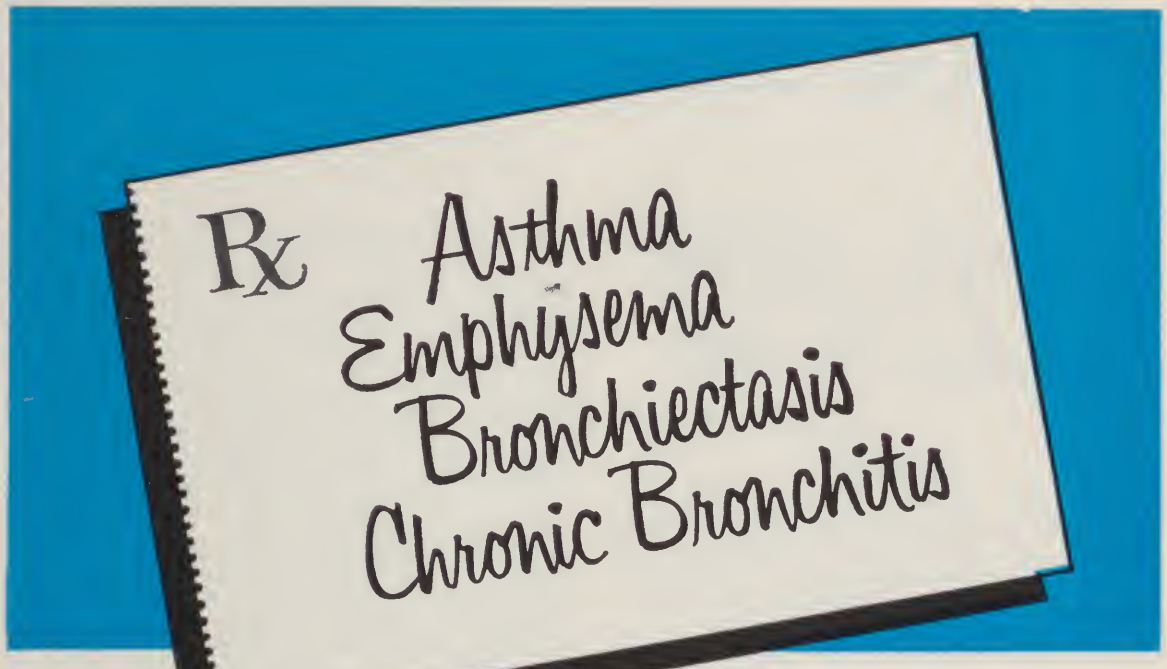
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BUSINESS SESSIONS

SEMIANNUAL MEETING
September 10, 1965

MINUTES

The 251st meeting, Semiannual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:40 A.M., Friday, September 10, 1965, at Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. An asterisk indicates an alternate delegate.

Doctors: *A. Andrew Alecce, Baltimore City; John G. Ball, Montgomery County; E. Irving Baumgartner, Council; *A. H. Barr, Somerset County; Richard D. Bauer, Council; Harry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Past President; Carlton Brinsfield, Allegany County; Frank E. Brumback, Washington County; Read N. Calvert, Montgomery County; Robert vL. Campbell, President; *Katherine A. Chapman, Montgomery County; Henry V. Chase, Council; Stuart Christhilf, Anne Arundel County; *David S. Clayman, Prince George's County; E. Paul Coffay, Jr., Baltimore City; Archie R. Cohen, Washington County; Ernest I. Cornbrooks, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; Louis C. Dobihal, Baltimore City; J. Sheldon Eastland, Past-President; William C. Ebeling, Council; Robert W. Farr, Council; James McC. Finney, Harford County; Russell S. Fisher, Council; Seymour Goldgraben, Cecil County; *Paul Guerin, Baltimore City; Oskar Gulbrandsen, Kent County; J. Roy Guyther, Council; William B. Hagan, Council; John C. Harvey, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; *Claude D. Hill, Baltimore City; James P. Jarboe, St. Mary's County; *Stephen Jones, Montgomery County; James R. Karns, Baltimore City; Fayne A. Kayser, Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, 2nd Vice-President; Howard F. Kinnamon, Past-President; Bender B. Kneisley, Past-President; C. Rodney Layton, Queen Anne's County; *Eugene Linberg, Baltimore City; *Deonis M. Lupo, Baltimore City; *George S. Malouf, Prince George's County; Wm. J. McClafferty, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald Mintzer, Baltimore City; William C. Morgan, Wicomico County; Frank K. Morris, Board of Medical Examiners; *Howard T. Morse, Montgomery County; Joseph E. Muse, Jr., Baltimore City; Charles F. O'Donnell, Past-President; A. Austin Pearre, Past-President; Wm. A. Pillsbury, Council; *Carolyn Pincock, Montgomery County; *Frank E. Poole, Wicomico County; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; *William F. Renner, Baltimore City; Eugene J. Riley, Baltimore City; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Edwin Ruzicka, Talbot County; *William J. Rysanek, Jr., Baltimore City; Emmanuel Schimunek, Baltimore City; Thaddeus C. Siwinski, Baltimore County; William B. Settle, Baltimore City; *R. Kennedy Skipton, Prince George's County; John N. Snyder, Baltimore County; Aaron C. Sollod, Baltimore City; Omar D. Sprecher, Jr., Washington County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; F. J. Townsend, Worcester County; Aaron H. Traum, Montgomery County; Thomas E. Van Metre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Hugh W. Ward, Calvert County; Lawrence R. Wharton, Jr., Baltimore City; Charles H. Williams, Baltimore County; Hans Wodak, Prince George's County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; Raymond M. Yow, Council; Israel Zeligman, Baltimore City; Mr. Walter N. Kirkman.

Present also for the meeting were staff personnel.

The President made certain announcements with regard to the conduct of business at the session.

MINUTES

The minutes of the April 21 and April 23 meetings, respectively, of the House of Delegates, annual session, having been distributed to the members, were amended by striking out of the April 21 meeting the following reports which were shown as being presented although no such reports were, in fact, presented:

Bylaws
Building Fund
Policy and Planning Committee
Joint Council for Improvement of the Health Care of the Aged
Medical Advisory Committee to the Red Cross Blood Bank Program

EMERITUS MEMBERSHIP

On the recommendation of the Council, the following members were elected to Emeritus Membership: Ralph Cohen, MD, Montgomery County; David Brewer, MD, Washington County; Margaret B. Ballard, MD, Baltimore City; Frank Wolbert, MD, Harford County.

COUNCIL REPORT

Dr. Fisher, on behalf of the Council, moved the following resolution which, after debate, was adopted:

> *Resolved,* That up to $15,000. from the educational fund be allocated to the Postgraduate Education, Preventive Medicine and Public Health and the Public Relations Committees to be utilized for a one-year, one-time demonstration project for the purpose of postgraduate education; specifically, to pay costs of rental of telephone

leased lines primarily to carry educational programs, as well as for other communications purposes; and to pay for installation and monthly service charges for equipment to be installed at the Faculty building for transmittal and receipt of such programs, it being understood that these Committees will report details of the program and the details of the expenditure of the funds to the Executive Committee for its approval, before any expenditures are made.

FACULTY DELEGATES TO THE AMA REPORT

The report of the Faculty's Delegates to the American Medical Association was filed.

BYLAWS COMMITTEE REPORT

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than a two-thirds vote:

ARTICLE II, Section 3

Amend Article II, Section 3, by adding to the first sentence the following: "and (3) active members of one component society of the Faculty who wish to maintain affiliation with another component society of the Faculty."

ARTICLE III, Section 1

Amend Article III, Section 1 (c) by striking out "$15.00" and inserting "$15.00 for those described in Article II, Section 3 (1) and (2)."

STANDING RULES CHANGE

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, moved the adoption of the following amendments to the Standing Rules of the House of Delegates, which, after debate and amendment, were adopted by more than a two-thirds vote:

Amend Standing Rule 2 by substituting for it the following:

"2. The privileges of the floor at meetings of the House of Delegates shall be extended to members of the Faculty who are not delegates, to their guests and to such members of the staff as may be necessary. Seating on a portion of the floor shall be reserved for them at all meetings of the House of Delegates. Non-members of the House may, at the request of a delegate, be extended the privilege of debating a pending motion by a three-fourths vote."

Amend Standing Rule 3 by striking out, "each member of the House on all," and inserting "any person enjoying the privileges of debate on each,"

POLICY AND PLANNING COMMITTEE REPORT

Dr. Bauer, Chairman of the Policy and Planning Committee, on behalf of the Committee, moved the adoption of the Committee recommendations. The recommendations were adopted after the President cautioned the House that adoption of this resolution would render Resolution 3 S/65 out of order.

EXPRESSION OF THANKS

An expression of thanks was voted to the authors of the report in recognition of the work done in this connection.

PROFESSIONAL FEE FUND COMMITTEE REPORT

Dr. Settle, on behalf of the Professional Fee Fund Committee, proposed presentation of a report to the House of Delegates. After debate and amendment, the following resolution was adopted, as amended.

Resolved, That the report of the Professional Fee Fund Committee be recommitted for revision and report at the next meeting of the House, provided that the revised report and the report in its original form be distributed to all delegates and a special meeting be called to consider it.

REFERENCE COMMITTEE REPORT

Dr. Hagan, on behalf of the Reference Committee, reported to the House with respect to Resolution 1 S/65, and recommended that it be adopted.

RESOLUTION 1 S/65 ADOPTED

The House adopted Resolution 1 S/65, which read as follows:

Whereas, The present Medical Care Program in the State of Maryland makes provision for payment of physicians' services only if rendered outside of the hospital; and

Whereas, An increasing number of Medical Care patients are being cared for by private practicing physicians in hospitals; now, therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland recommends that the usual and customary fees be paid to private practicing physicians rendering care to hospitalized medical care program patients.

"USUAL" AND "CUSTOMARY" DEFINITIONS ADOPTED

The House also adopted the following definitions as recommended by the Reference Committee:

"Usual—The 'usual' fee is that fee usually charged for a given service, by an individual physician to his private patient (i.e., his own usual fee)."

"Customary—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

RESOLUTION 2 S/65 ADOPTED

Dr. Hagan, on behalf of the Reference Committee, recommended that Resolution 2 S/65 be adopted.

The House adopted Resolution 2 S/65, which read as follows:

Whereas, The Medical and Chirurgical Faculty of the State of Maryland recognizes the need for adequate preparation for natural disasters; and

Whereas, Medieal and other civil defense supplies which are financed wholly or in part by state and federal funds eould be used to save human lives and mitigate human suffering in many natural disasters; and

Whereas, The Federal Civil Defense Act of 1950 as presently worded, is entirely attack-oriented; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland support the Amerieau Medical Association in urging the passage of federal legislation, or an amendment to existing laws, that will provide a definition of civil defense to include natural disasters as well as war disasters.

RESOLUTION 3 S/65 RULED OUT OF ORDER

The President ruled that Resolution 3 S/65 was out of order, in view of the fact that the House had already adopted the report of the Policy and Planning Committee which conflicted with it.

RESOLUTION 4 S/65 ADOPTED AS AMENDED

Dr. Hagan, on behalf of the Reference Committee, moved that Resolution 4 S/65 be amended and that, as amended, it be adopted. Resolution 4 S/65, after amendment and debate, was adopted as follows:

Resolved, That the Medical and Chirurgieal Faculty of the State of Maryland reaffirms its position that it is unalterably opposed to the denial of membership privileges and responsibilities in eomponent medical societies to any duly lieensed or qualified physician beeause of race, color, religion, ethnic affiliation, or national origin.

PROPOSAL REJECTED

The following motion, moved by Dr. Cornbrooks, was rejected:

Resolved, That the conflicting reports regarding insurance policies be reviewed by the Insurance Commission to assure the Faculty it is getting the best coverage for the premiums paid.

LOCATION OF SEMIANNUAL MEETING

The following motion on being offered to the House by Dr. Settle was rejeeted:

Resolved, That the Program Committee be requested to look into other possible locations for the Semiannual meeting of the Faculty, such as Williamsburg, Va., Ocean City and Atlantic City, New Jersey.

The President then made several announcements.

Whereupon, by unanimous consent, the House adjourned *sine die* at 12:15 PM.

William A. Pillsbury, M.D., Secretary

REPORTS

To the House of Delegates

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Your three delegates to the Amerieau Medical Association's House of Delegates attended all sessions of the House of Delegates in New York City, June 20-24, 1965. In addition, one of the delegates, J. Sheldon Eastland, M.D., was assigned to the Reference Committee on Miscellaneous Business. The other delegates, the senior alternate delegate, William B. Hagan, M.D., and the executive secretary attended the hearings of the various Reference Committees.

Health Care Legislation

Most controversial issue before the House was that of nonpartieipation under any so-called "Medicare" laws that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Dr. Appel's inaugural address.

The House recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In adopting a substitute resolution, the House declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality, and availability of medical eare which has been traditional in our country.

"When the fate of the pending medieare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary.

"In keeping with the testimony before your Committee, and the expressed policies of this House, this action should in *no way* be interpreted as a ehange in Section 6 of the *Principles of Ethics* of the American Medical Association, which plainly states: 'A physieian should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care'; and that this House of Delegates reaffirm the prineiples of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its speeial meeting February 7, 1965, and amended to read as follows:

'(1) No person needing health care shall be denied such care because of the inability to pay for it.

'(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

'(3) Every level of government, municipal, county, state, and federal, should assume a responsible share in the financing of such programs.

'(4) The health care provided by such programs shoul l be adequate and should be equal to that available to those who can afford to pay.

'(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

'(6) Administration of such progrom should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

'(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated, and practical.
'(8) Any such health care programs should provide funds only, and not direct services.
'(9) Funds for such programs may come from general tax revenues and not from social security taxes.' "

Offer to President Johnson

In a related action urging that government seek the advice of the medical profession on health legislation, the House adopted a resolution which included the following statements:

"This House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.

"The American Medical Association make every effort to continue, and where necessary, to expand it communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

The DeBakey Commission Report

In considering seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer, and Stroke, the House adopted a substitute statement which resolved that:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members.

The Gundersen Committee

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

The House adopted a reference committee report saying:

"It was apparent that if the organization of the House of Delegates of the American Medical Association, which is of paramount importance to the efficient and productive operation of the Association, is to be thoroughly studied by the delegates, more time will be required."

The Gundersen Committee was appointed an ad hoc unit at the directive of the AMA House in June, 1963. The committee, which is chaired by Gunnar Gundersen, MD, La Crosse, Wis., a past president of the AMA, brought in an extensive 35-page report.

The committee pointed out that certain aspects of its work were unfinished, particularly those dealing with the function of the AMA scientific sections. The AMA House action recommended that the committee continue its study of scientific sections.

Organization of a New Section

In a report to the Board of Trustees, the Council on Postgraduate Programs affirmed its belief that the establishment of a new section is an important change in the AMA structure, and submitted a procedure for evaluating the qualifications for a new section and the scientific programs of all sections.

In brief, this procedure provides that (1) the group requesting formation of a new section submit to the Executive Vice President a written request for approval; (2) the request be transmitted by the Board to the Council on Postgraduate Programs for evaluation of the petition; (3) if approved by the Council, a mandatory trial period of two years as presently in effect be provided under the auspices of the Council; and (4) after such trial period, a recommendation for acceptance or denial of the petition for the establishment of a section be made to the Board.

The House approved the recommendation, with certain word changes, and suggested that it be sent first to the Gundersen Committee and then to the appropriate AMA council for consideration.

Elimination of Discriminatory Practices by County Medical Societies

Noting that in 1964 the AMA House of Delegates took a strong position on civil rights and that the situation is steadily improving, the Reference Committee recommended reaffirmation of foregoing policies and adoption of the following resolution:

"That, within the framework of its constitution and bylaws, the American Medical Association continue to use all of its influence

to end discriminatory racial exclusion policies or practices by any medical societies which permit such policies or practices to exist."

In 1964 the AMA declared itself "unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin . . ."

Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals. A communication to this effect has been sent to the chief of medical staff of all general hospitals in Maryland.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology, and physical medicine in hospitals.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people," specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the Board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the Board for study a resolution calling for "a program of purchase of health insurance . . . in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the Board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

Received a series of resolutions urging approval of an American Board of Family Practice. All were referred to the Council on Medical Education.

Urged the Council on medical education to establish a standard date of appointment for all approved residency training programs.

Encouraged state and county medical societies to participate in the formation of state associations of the professions, "to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of a great benefit."

Amended the bylaws to provide that the vice president shall succeed to the presidency should the president die, resign, or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

Opening Session

Dr. Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of personal opinion, "we do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." Outgoing President Donovan F. Ward pointed out:

"If it were true that the public climate was the dominant factor affecting the decisions of those who made legislative history, we now would be winning both in the House and the Senate."

Additional Items

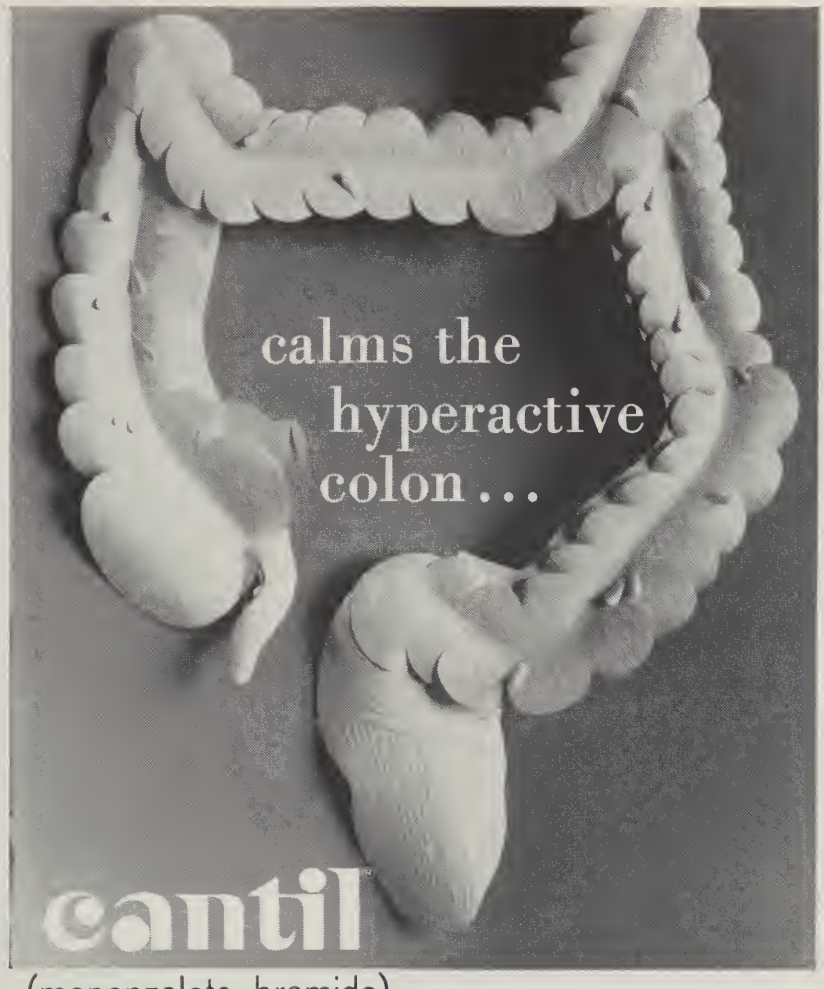
The AMA House of Delegates also adopted the following policy statement:

"It is recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported programs should be on the basis of usual and customary fees."

The House also adopted the following interpretations of the words "usual," "customary," or "reasonable" fees:

USUAL—The "usual" fee is that fee usually charged for a given service by an individual physician to his private patient (i.e., his own usual fee).

CUSTOMARY—A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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limited geographical area (socioeconomic area of a metropolitan area or socioeconomic area of a country).

REASONABLE—A fee is "reasonable" when it meets the above two criteria or, in the opinion of the responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question.

Payment of Interns and Residents by Blue Shield

The House adopted a clearcut policy on payment by Blue Shield for the services of residents and interns by stating that

"This House of Delegates record itself as approving and supporting the principle that Blue Shield medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients."

Your Delegates have referred appropriate items to various Faculty committees for their information and any action deemed appropriate after study of the items involved.

Respectfully submitted,
Robert VanL. Campbell, M.D.
J. Sheldon Eastland, M.D.
Russell S. Fisher, M.D.
William B. Hagan, M.D., *Senior Alternate Delegate*

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

The Bylaws Committee met on May 26, 1965, to consider various items to come before it. We have the following Bylaws amendments to propose at this time:

ARTICLE II, Section 3

Amend Article II, Section 3, by adding to the first sentence the following: "and (3) active members of one component society of the Faculty who wish to maintain affiliation with another component society of the Faculty."

OLD

Section 3. *AFFILIATE MEMBERS* shall consist of members in good standing of all component societies who are: (1) physicians licensed in Maryland who are active members of another constituent association of the American Medical Association; and (2) formerly active or associate members who have removed from the State and wish to retain affiliation with the Faculty. They shall have the rights accruing to associate members except that of physicians' defense.

NEW

(CAPS portion to be added.)

Section 3. *AFFILIATE MEMBERS* shall consist of members in good standing of all component societies who are: (1) physicians licensed in Maryland who are active members of anothers constituent association of the American Medical Association; and (2) formerly active or associate members who have removed from the State and wish to retain affiliation with the Faculty AND (3) ACTIVE MEMBERS OF ONE COMPONENT SOCIETY OF THE FACULTY WHO WISH TO MAINTAIN AFFILIATION WITH ANOTHER COMPONENT SOCIETY OF THE FACULTY. They shall have the rights accruing to associate members except that of physicians' defense.

ARTICLE III, Section 1

Amend Article III, Section 1 (c) by striking out "$15.00" and inserting "$15.00 for those described in Article II, Section 3 (1) and (2)."

OLD

(c) *For Affiliate Members:* $15.00

NEW

(CAPS portion to be added.)

(c) *For Affiliate Members:* $15.00 FOR THOSE DESCRIBED IN ARTICLE II, SECTION 3 (1) and (2)

The Bylaws Committee recommends the following change in the Standing Rules of the House:

Amend Standing Rule 2 by substituting for it the following:

OLD

(Italics to be deleted.)

2. Meetings of the House of Delegates shall be attended only by members of the House, members of the Faculty and their guests, and such members of the staff as may be necessary.

NEW

(CAPS portion to be added.)

2. THE PRIVILEGES OF THE FLOOR AT MEETINGS OF THE HOUSE OF DELEGATES SHALL BE EXTENDED TO MEMBERS OF THE FACULTY WHO ARE NOT DELEGATES, TO THEIR GUESTS AND TO SUCH MEMBERS OF THE STAFF AS MAY BE NECESSARY. SEATING ON A PORTION OF THE FLOOR SHALL BE RESERVED FOR THEM AT ALL MEETINGS OF THE HOUSE OF DELEGATES. MEMBERS OF THE FACULTY WHO ARE NOT DELEGATES MAY, AT THE REQUEST OF A DELEGATE, BE EXTENDED THE PRIVILEGE OF DEBATING A PENDING MOTION BY A THREE-FOURTHS VOTE.

Amend Standing Rule 3 by striking out, "by each member of the House"

OLD

(Italics to be deleted.)

3. Debate at all sessions of the House of Delegates shall be limited to one speech of three minutes by *each member of the House* on all debatable motions.

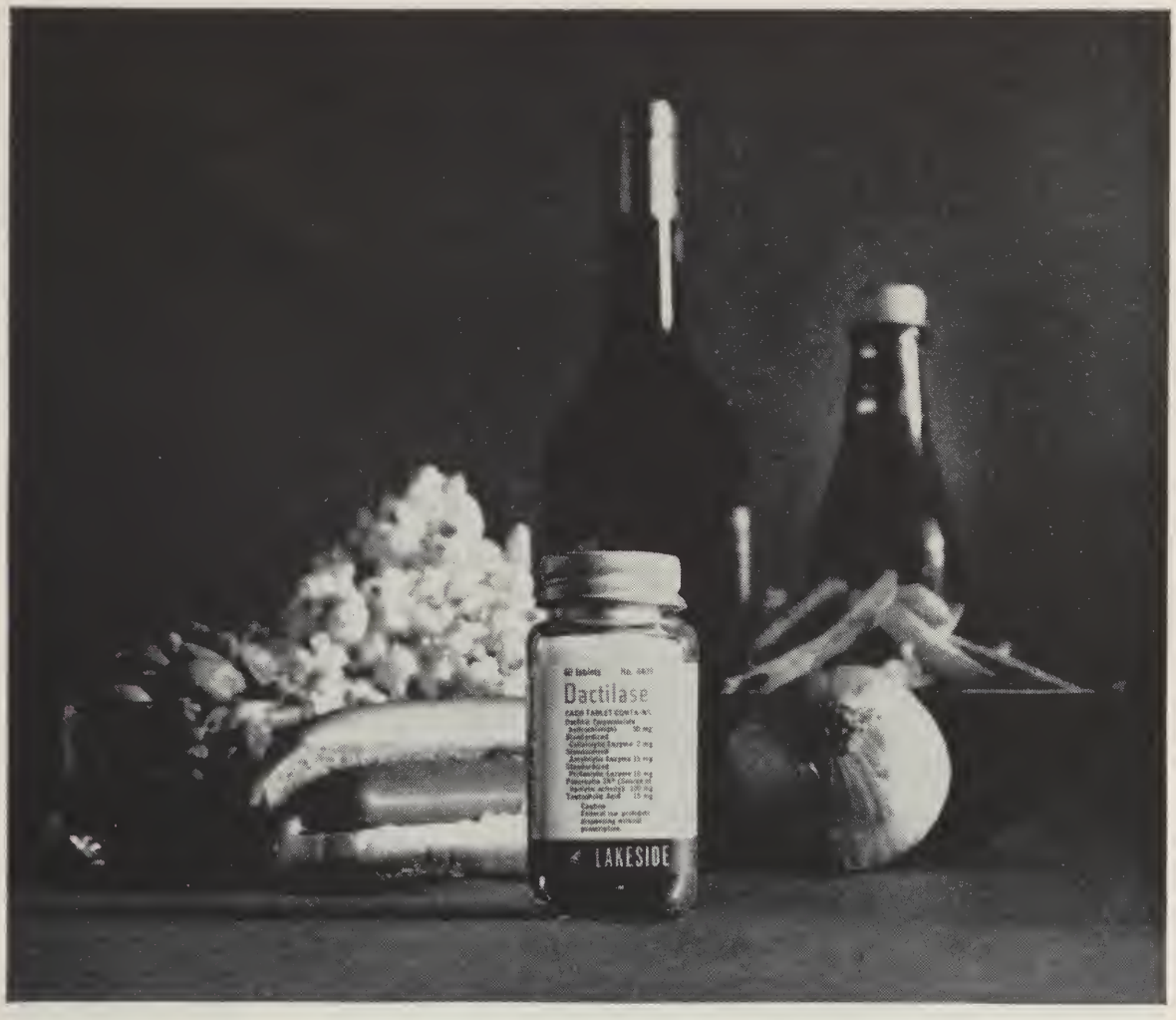
NEW

3. Debate at all sessions of the House of Delegates shall be limited to one speech of three minutes on all debatable motions.

Explanation: At the present time, it is the policy of the House of Delegates to permit guests to speak on any motions or resolutions before the House provided the House agrees. This will formalize such present policy in writing, subject at all times, of course, to vote by the House itself.

The Bylaws Committee also considered several other items that had been addressed to it.

1. A request from M. B. Levin, M.D., with respect to changing our Bylaws so that individual members could



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

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vote in person or by proxy to elect officers and on other actions of the Faculty. Dr. Levin entered suit against the Faculty and the Baltimore City Medical Society requesting the courts to so order these groups to comply with his request. The Baltimore City lower court failed to hold for Dr. Levin, whereupon he appealed this decision to the Superior Court of Baltimore City. The Superior Court upheld the lower court's decision. He then appealed this to the Court of Appeals in Annapolis. After requests for three deferments in trial date, the Court of Appeals denied an additional request for trial deferment and held that the lower courts had acted correctly.

Following this, Dr. Levin placed his request with the Baltimore City Medical Society at its April, 1965, business session. The City Society decided against giving consideration to the request.

The Bylaws Committee feels that:

(a) Dr. Levin is now attempting to obtain his wishes by going over the heads of the Baltimore City Medical Society. Such request should, properly, come with the support and the endorsement of that Society.

(b) Dr. Levin's case has been found against him by courts of law in Maryland.

(c) Provision is already in the Bylaws for submitting matters of sufficient importance to a referendum, and the House of Delegates has that authority. Article VI, Section 1 (c) clearly spells this out.

The Bylaws Committee, therefore, feels that no action should be taken on the request of Dr. Levin on this subject.

2. This House of Delegates referred the recommendation of the retiring treasurer to the Bylaws Committee that a Finance Committee be established. The Bylaws several years ago provided for such a Committee, and it was found that it was seldom used. Consequently, this committee was abolished.

The Bylaws Committee has discussed this with the new treasurer and has suggested that we wait for a period of time to see if there is a real necessity for the provision of such a committee. The Bylaws Committee, therefore, recommends that we take no action at this time on this recommendation and that a further report be made at the Annual Meeting, April, 1966.

3. The Bylaws Committee also considered the possibility of a change in the manner of election of the members of the Board of Medical Examiners; that is, that such members be elected in the same manner as Faculty officers. It was felt that these should continue to be elected at a Faculty general meeting, as is presently provided for in the Bylaws and that no change in this procedure be made.

4. The Bylaws Committee also considered a proposal which was under discussion in a component society requiring that 60 days notice be given for special or other House of Delegates meetings when an assessment is up for consideration. Because it had no concrete proposal or information on this suggestion, the Bylaws Committee felt it should take no action until such time as a proposal or recommendation is made in this regard.

Respectfully submitted,

Charles F. O'Donnell, M.D., *Chairman*
M. McKendree Boyer, M.D.
Albert E. Goldstein, M.D.
Edmond J. McDonnell, M.D.

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates

Informal interviews and discussions with physicians regarding PL 89-97 (Medicare law) seem to indicate that opinions vary as to what should be done, if anything. These concepts run the gamut from militant non-participation to docile acquiescence. It is evident that some general, though flexible, policy should be decided upon. This is brought more clearly in evidence by the recent AMA opinion that hasty reactions might run afoul of the law. It is, therefore, incumbent on the Faculty to provide its membership with as much information as posible, both PRO AND CON, on PL 89-97, so that they may be guided by their own individual conscience in reaching any decisions on this important and far-reaching change in the concept of providing medical care to the citizens of this country.

With these thoughts in mind, it is therefore recommended as follows:

Role of the Faculty

1. The proper role of the Medical and Chirurgical Faculty of the State of Maryland is to assemble and distribute factual information to its membership. It is entirely within the province of the Faculty's House of Delegates to render an opinion as to whether the law and its implementation presents a reasonable, workable and proper atmosphere in which medical care can be offered effectively to the public, *so long as there is no agreement, coercion, penalty, or threat, actual or implied, and as long as it is stressed that an individual physician may reject or accept the opinion of the Society without fear of recrimination.*

2. It is the responsibility of the Faculty to have its membership well informed on medicare, pro and con. Every means should be used to encourage all physicians to read, think, and digest all information on both sides of this subject.

3. The Faculty should consider carefully the *TOTAL* picture of PL 89-97, before any statement is made. The law *and its implementation* (rules and regulations) should be studied in their entirety. Component societies should be made aware of pitfalls in hasty action. Individual members should be provided a factual, noncritical summary and clarification of the law and its implementation as soon as this information is available. The effect of non-compliance or compliance on the availability of hospital inpatient and outpatient and private physician's services, from the patient's viewpoint should be as thoroughly assessed as is possible.

4. If the Faculty is asked to form committees or if officers are asked to meet with agencies of the government regarding PL 89-97, it should be made abundantly clear that this does not imply endorsement of the law by our entire membership but is an effort to work out details for those of our members who wish to participate.

Legal Implications

1. Any action taken by the Faculty should be cleared adequately by legal counsel, including this document.

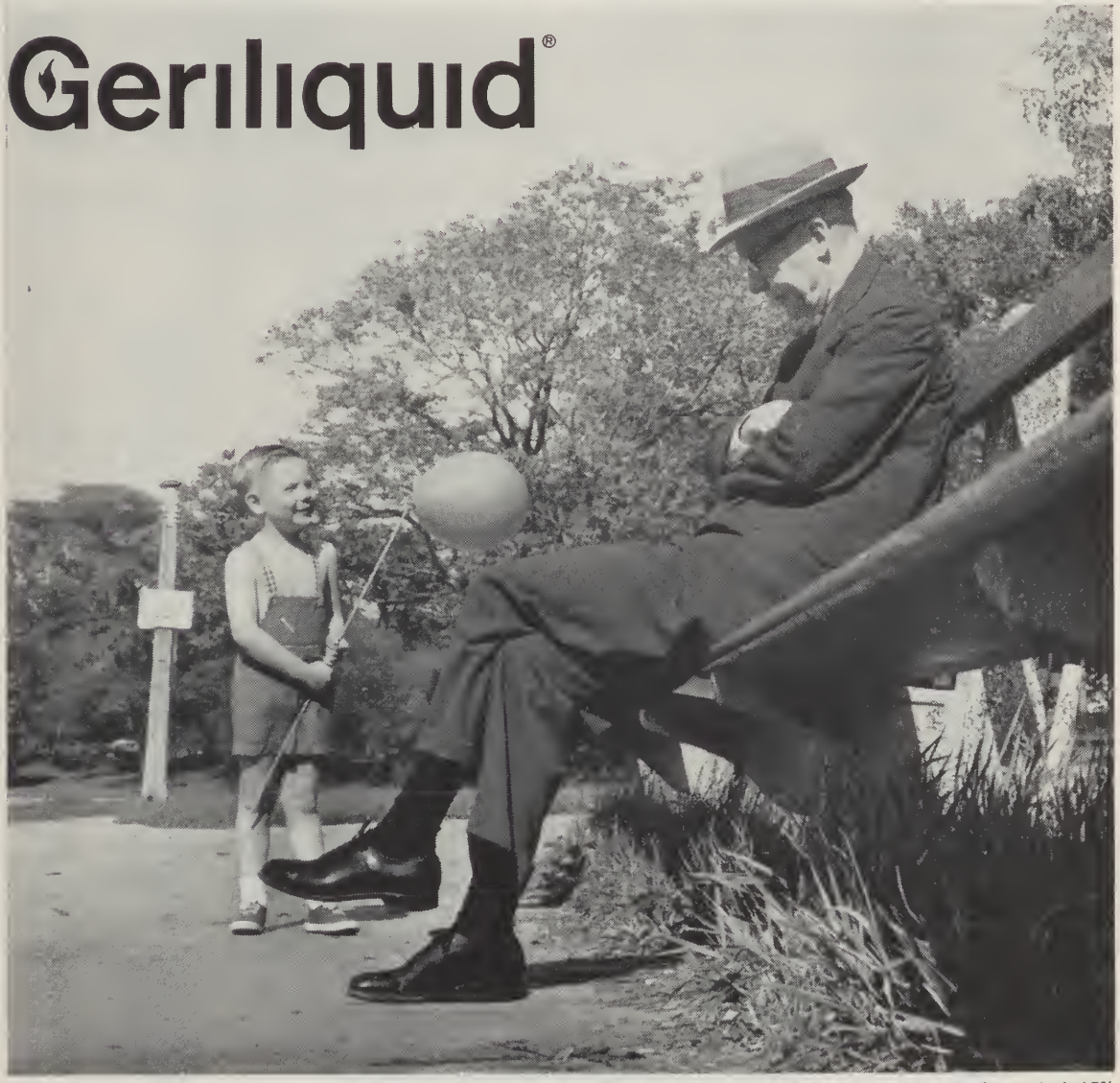
2. Legal services of the Faculty's legal counsel should be made available to component societies on a con-

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

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sulting basis; and component societies should be encouraged to avail themselves of these services, insofar as PL 89-97 and its implementation are concerned.
3. The inherent right of the individual physician to act independently, of his own free will, without coercion, threat, loss of membership, actual or implied, should be strongly reaffirmed. The membership should be informed of this, as well as the fact that there is not written into PL 89-97 any obligation to comply; that it is the privilege of each individual member to decide for himself whether to participate and that he may decide in the negative "without breaking the law." It is a physician's right to contract or not contract with a patient.
4. Faculty members should be informed that "due notice" should be given patients already under his care, together with the legal implications if such notice is not given should the physician decide not to participate. It would be likewise a public service to inform patients in an ethical manner of participation.
5. Full details should be given physicians with respect to their "rights" insofar as hospital staff membership is involved. The effect of compliance or non-compliance on such privileges should be adequately and fully assessed.

Ethical Concepts

There are certain ethical concepts that are basic. These are repeated here for emphasis.

1. The uppermost consideration of the individual physician should be *his* opinion as to whether he can render good, ethical, beneficial medical care to the public under the circumstances that develop when the total picture is available. This is an individual decision to be made by him from his own individual appraisement of all the facts.
2. Some of the factors in such physicians' self-determination as regards compliance or non-compliance include (a) quality of care to be rendered under the provisions of the law, (b) availability of hospital and nursing home beds, (c) the rendering of outpatient hospital services, (d) methods of payment, (e) use of utilization committees, (f) and most important, the far-reaching effects of this law, good or bad, for future generations of American citizens.

Procedural Suggestions

The Policy and Planning Committee recommends the following partial list of procedures that can be followed in implementing some of the above suggestions:

1. Copies of AMA correspondence which outlines legal opinion and answers the questions with respect to some of the issues raised above be sent to all Medical and Chirurgical Faculty members.
2. Copies of this policy statement, if approved, be distributed to all members.
3. Mailing and distribution of all pertinent and relevant literature currently and as it becomes available to all members, such material for distribution being adequately cleared with legal counsel.

Recommendations

1. **The Faculty's House of Delegates endorse this policy report of the Policy and Planning Committee.**
2. **The Faculty's House of Delegates approve expenditure of funds from the accrued special assessment to implement this policy report.**
3. **The Faculty's House of Delegates authorize the Council and Executive Committee to delegate to Faculty committees and staff the responsibility for carrying out the instructions of the House of Delegates as embodied in the acceptance of this report.**

Respectfully submitted,

Richard D. Bauer, M.D., *Chairman*
J. Thompson Ambler, M.D.
A. N. Barr, M.D.
Leon W. Berube, M.D.
Robert vL. Campbell, M.D.
Thomas V. Craig, M.D.
Luis M. Cuza, M.D.
Roberto de Villarreal, M.D.
Russell S. Fisher, M.D.
George E. Groleau, M.D.
J. Ralph Horky, M.D.
Irvin G. Hoyt, M.D.
John C. Hyle, M.D.
Arthur T. Keefe, Jr., M.D.
Henry P. Laughlin, M.D.
Herbert H. Leighton, M D.
Karl F. Mech, M.D.
A. J. Mirkin, M.D.
William C. Morgan, M.D.
William H. Mosberg, Jr., M.D.
William A. Pillsbury, M.D.
Harold B. Plummer, M.D.
J. Morris Reese, M.D.
Norman E. Sartorius, Jr., M.D.
William L. Stewart, M.D.
James B. Thomas, M.D.
William A. Williams, M.D.
Eldridge H. Wolff, M.D.
Arthur O. Wooddy, M.D.

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on August 26, 1965, at the Faculty Building. It was impressed by the attendance of parties interested in the resolutions that were scheduled to come before it. Each person was given the opportunity to speak and to express his personal views on the various resolutions. They were discussed fully and completely. All decisions were reached in accordance with the Faculty's Bylaws, Article X, Section 22.

As has been the custom, your Committee will recommend action to the House. The question, however, will be on the Resolution itself and not upon the Committee report.

*Resolution 1 S/65**

Submitted on: July 6, 1965
Introduced by: Anne Arundel County Medical Society
Subject: Payment of Physicians by the State of

*Resolution adopted. See minutes.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (Iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep Intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran Injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

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(iron dextran injection)



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Maryland for Services now Provided Free to In-Hospital Medical Care Patients

Whereas, The present Medical Care Program in the State of Maryland makes provision for payment of physicians' services only if rendered outside of the hospital; and

Whereas, An increasing number of Medical Care patients are being cared for by private practicing physicians in hospitals (where there is no house physician staff); now, therefore, be it

(*Resolved,* That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland recommend to the proper parties that a fee schedule be adopted by the Medical Care Program to make payment to all physicians rendering care to hospitalized Medical Care patients in hospitals where there is no internship or residency training program.)

(*Resolved,* That such fee schedule be drawn up after consultation with the Fee Schedule Committee of the Medical and Chirurgical Faculty of the State of Maryland, such fee schedule being of a magnitude which would still encourage the admission of these patients to teaching hospitals when possible.)

RESOLVED, THAT THE HOUSE OF DELEGATES OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND RECOMMENDS THAT THE USUAL AND CUSTOMARY FEES BE PAID TO PRIVATE PRACTICING PHYSICIANS RENDERING CARE TO HOSPITALIZED MEDICAL CARE PROGRAM PATIENTS.

{CAPS Portions inserted; parentheses struck out. Changes made by authority of the Anne Arundel County Medical Society delegation in attendance at the Reference Committee meeting.}

In April, 1962, a similar resolution was considered by this House of Delegates. It was defeated at that time. However, the profession was then engaged in combatting the threat of "Medicare," which has now become law.

It is surprising to learn that many of these people who have been taken care of at no charge to them or any governmental agency are not aware of this. In fact, most of these individuals believe the physician is reimbursed by "someone" for the services rendered to them. In addition, the Faculty has endeavored for some years now to have state authorities indicate on the recipient's medical care card that in-hospital medical care is provided to them by physicians at no cost to any person or agency. The Faculty has been unsuccessful in trying to work out any satisfactory solution to this proposal.

In June, 1965, the Council adopted the following statement:

> "The Council affirms the physician's right to a reasonable remuneration for medical services rendered, whether inpatients or outpatients, in the medical care programs; and for whose care the government has assumed financial responsibility."

Later that same month the American Medical Association's House of Delegates adopted the following statement:

> "It is recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported programs should be on the basis of usual or customary fees."

The AMA also adopted the following definitions of "usual" and "customary":

> "Usual—The 'usual' fee is that fee usually charged for a given service, by an individual physician to his private patient (i.e., his own usual fee)."
> "Customary—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

In the light of this, the Reference Committee recommends that Resolution 1 S/65 be adopted, and that the House of Delegates adopt the following definitions of "usual" and "customary" as adopted by the AMA House of Delegates in June, 1965:

> **"Usual—The 'usual' fee is that fee usually charged for a given service, by an individual physician to his private patient (i.e., his own usual fee)."**
> **"Customary—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."**

*Resolution 2 S/65**

Submitted on: July 9, 1965
Introduced by: Medical Emergency Disaster Service Committee
Subject: Support of American Medical Association in Amendment of Federal Laws providing for a Redefinition of Civil Defense

Whereas, The Medical and Chirurgical Faculty of the State of Maryland recognizes the need for adequate preparation for natural disasters; and

Whereas, Medical and other civil defense supplies which are financed wholly or in part by state and federal funds could be used to save human lives and mitigate human suffering in many natural disasters; and

Whereas, The Federal Civil Defense Act of 1950 as presently worded, is entirely attack-oriented; therefore, be it

*Resolution adopted. See minutes.



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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland support the American Medical Association in urging the passage of federal legislation, or an amendment to existing laws, that will provide a definition of civil defense to include natural disasters as well as war disasters.

This resolution is similar to one adopted by the AMA House of Delegates in June, 1965. Maryland state law already provides for the definition of civil defense activities to include natural disaster.

The Reference Committee sees no reason why this resolution should not be approved and, therefore, recommends its adoption.

Resolution 3 S/65†

Submitted on: July 16, 1965
Introduced by: William T. Layman, MD, Hagerstown, Maryland
Subject: Non-Participation on Part of Faculty and its Individual Members in (H.R. 6675; PL 89-97) or Measures Similar to This

Whereas, The United States Congress has adopted (H.R. 6675; PL 89-97); and

Whereas, This legislation is not in the best interest of the general public and the profession alike, and will unquestionably lead to a deterioration of the present high quality, first class medical care; and

Whereas, The Medical and Chirurgical Faculty of the State of Maryland has repeatedly gone on record as opposed to legislation of this type; now, therefore, be it

(Whereas, The Washington County Medical Society has passed a resolution similar to the following;)
Resolved, That the Medical and Chirurgical Faculty of the State of Maryland reaffirms

(a) (both) its position to render high quality care to everyone and calls on its members to do likewise, while at the same time restating its uncompromising stand against socialistic legislation of the type embodied in (H.R. 6675;) PL 89-97;

(b) NONETHELESS reserving unto (itself and) its members the unquestioned right of non-participation under the provisions of (H.R. 6675;) PL 89-97;

(c) reaffirms the right of individual members of this society, while continuing to render medical care as always to their patients, to refuse to participate with the program as outlined in (H.R. 6675) PL 89-97 and specifically affirms that its members have the right to refuse to sign any papers relative to (H.R. 6675) PL 89-97, to refuse to execute any certificate as described in this legislation, and to refuse to accept any fees from any agency of the United States Government under the provisions of this Act.

{ CAPS PORTION inserted; parentheses }
{ struck out by request of sponsor }

A complete study of PL 89-97 indicates that it contains many items that the medical profession, in all good faith, should not oppose. It would be unwise for the Faculty to oppose by non-participation a public law passed by the U. S. Congress.

Your Reference Committee is of the opinion that Resolution 3 S/65 NOT be adopted, and so recommends.

*Resolution 4 S/65**

Submitted on: July 16, 1965
Introduced by: Jonas R. Rappeport, MD, C. Lee Randol, MD, Theodore Patterson, MD, Bernard Harris, Jr., MD, John T. Chissell, MD, and Emerson C. Walden, MD
Subject: Establishment of a Civil Rights Committee of the Medical and Chirurgical Faculty

Whereas, The report of the Subcommittee on Medical Education and Research of the Committee on Medical Care of the Maryland State Planning Commission recommends that the Medical and Chirurgical Faculty of the State of Maryland meet, in the immediate future, its leadership responsibility to accelerate the trend towards equal opportunities in regard to admission to medical school, and as regard to the availability of internships, residency and hospital staff appointments; and

Whereas, The demonstration of racial tolerance is inherent in the highly moral creed of the medical profession; and

Whereas, The House of Delegates, in April of 1962 adopted a resolution stating that the Medical and Chirurgical Faculty of the State of Maryland urges its members to implement the principles of racial tolerance in all health facilities and services wherein they have influences; and

Whereas, There has been concern expressed both publicly and privately as to the integration of various health facilities in the State; now, therefore, be it

Resolved, That the President of the Medical and Chirurgical Faculty of Maryland shall forthwith appoint a Civil Rights Committee for the purpose of investigating the effect of Resolution 1 A/62 upon the implementation of the principles of racial tolerance in all health facilities and services, and that this Committee will make a report at the next meeting of the House of Delegates as to its findings and make recommendations as to any necessary further action by the

†Resolution ruled out of order. See minutes.

*Resolution adopted as amended. See minutes.

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Medical and Chirurgical Faculty of Maryland to assure racial tolerance in the areas of our influence; and

Resolved, That this Committee should be composed of between eight and twelve members, all of whom have, by past actions, indicated a positive interest in the area of Civil Rights.

In order that the House may be familiar with the Resolution 1 A/62, adopted in April, 1962, it is quoted as follows:

House of Delegates
Adopted, Friday, April 6, 1962
Resolution 1 A/62

Submitted on: February 6, 1962
Introduced by: Bernard Harris, Jr., M.D., and Emerson C. Walden, M.D.
Subject: FULL RACIAL INTEGRATION IN ALL THE HEALTH FACILITIES AND SERVICES OF BALTIMORE AND THE STATE OF MARYLAND

Whereas, The report of the Subcommittee on Medical Education and Research of the Committee on Medical Care of the Maryland State Planning Commission recommends that the Medical and Chirurgical Faculty of the State of Maryland meet, in the immediate future, its leadership responsibility to accelerate the trend toward equal opportunity as regards admission to Medical schools, and as regards the availability of internships, residencies, and hospital staff appointments; and

Whereas, The peaceful course of racial integration within the health facilities of the United States Armed Forces, Public Health Service and Veterans Administration has shown that integration is necessary for efficiency and economy in the operation of these facilities; and

Whereas, The practice of full racial integration in the staffing of these facilities has proven favorable to the development of professional skills and the full exchange of medical knowledge; and

Whereas, The same peaceful progress of racial integration within some non-governmental health facilities in Baltimore, the State and throughout the country has demonstrated that integration contributes to the efficient and economic operation of these community services; and

Whereas, The practice of full racial integration in the staffing of some non-governmental health facilities in Baltimore, the State and throughout the country has also proven favorable to the development of professional skills and the full exchange of medical knowledge; and

Whereas, The shortage of health facilities and personnel make it imperative that inefficiencies and duplications be eliminated; and

Whereas, The demonstration of racial tolerance is inherent in the highly moral creed of the medical profession; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urge its members to implement the principles of racial tolerance in all health facilities and services wherein they have influence as staff members.

There are many groups that are working on the problems indicated in Resolution 4 S/65:

1. The Hospital Council of Maryland has worked with interested parties for several years in attempting to solve many of these problems. Much progress has been made.
2. The Baltimore Community Relations Commission is currently conducting a study amongst the Baltimore Area Hospitals with respect to employment and other practices of hospitals.
3. The State Health Department is currently conducting investigations and studies dealing with hospital policies; and is exerting strong pressure in these areas.
4. The Federal Government has investigating teams looking into violations of the 1964 Civil Rights Act which are alleged to be evident at five hospitals in Maryland.

The Faculty has for many years accepted members into the Society based on their qualifications without regard to race, color, religion, ethnic affiliation, or national origin. We know of no complaint from any individual physician in Maryland who has been denied equal opportunities based on any of the foregoing.

The Mediation Committee has recommended to the Council that it adopt the following:

"The Medical and Chirurgical Faculty of the State of Maryland is unalterably opposed to the denial of membership privileges and responsibilities in component medical societies to any duly licensed or qualified physician because of race, color, religion, ethnic affiliation, or national origin; and

"The Medical and Chirurgical Faculty of the State of Maryland calls upon all component societies and all individual members of the Faculty to exert every effort to end every instance in which such equal rights, privileges or responsibilities are denied."

At the time of writing this report, this matter was to be acted upon at the Council meeting scheduled for September 9, 1965.

The Faculty has no jurisdiction over actions of individual hospitals. Collection of data as suggested by this resolution would not necessarily mean that the problems, if there are any, would be resolved.

Your Reference Committee, therefore, recommends that Resolution 4 S/65 NOT be adopted, but offers to the House of Delegates adoption of the recommendation of the Mediation Committee which, in resolution form, is as follows:

***RESOLVED,* That "the Medical and Chirurgical Faculty of the State of Maryland is unalterably opposed to the denial of membership privileges and responsibilities in component medical societies to any duly licensed or qualified physician because of race, color, religion, ethnic affiliation, or national origin; and**

***RESOLVED,* That "the Medical and Chirurgical Faculty of the State of Maryland calls upon all component societies and all individual members of the Faculty to exert every effort to end every instance in which such equal rights, privileges or responsibilities are denied."**

The Reference Committee wishes to thank those who took the time to appear before it, as well as the Committee members and the office staff for their research and assistance in preparing this report.

Your Committee also again urges individual members, as well as members of the House of Delegates to take advantage of the opportunity of appearing at the meeting and expressing themselves on the subjects under discussion.

Respectfully submitted,
William B. Hagan, MD, *Chairman*
De Witt E. DeLawter, MD
Everett S. Diggs, MD
William G. Helfrich, MD
Howard F. Kinnamon, MD

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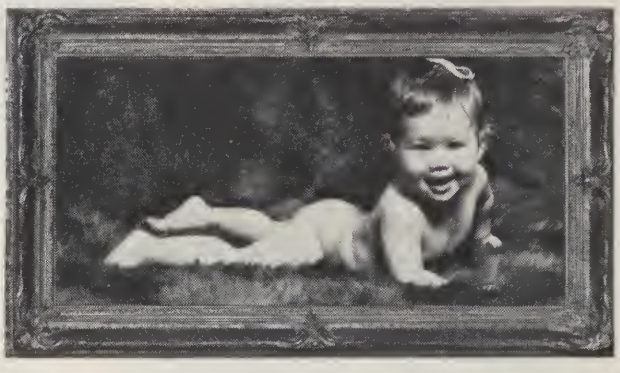
Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

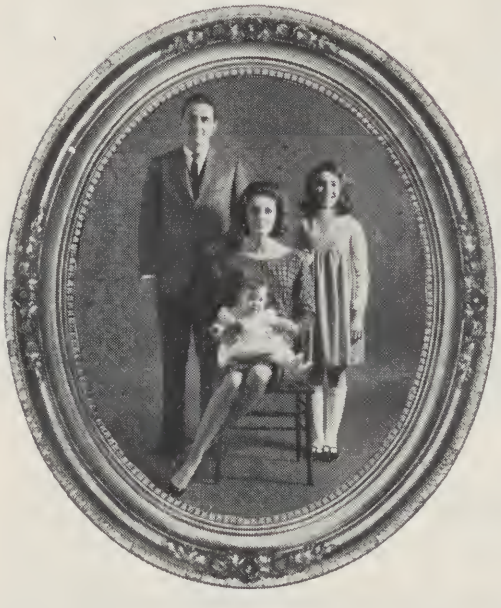
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

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BALTIMORE COUNTY

The October meeting of the Baltimore County Medical Society was held at the St. Agnes Hospital.

The scientific portion of the meeting featured a discussion on "Growth and Development in Children and Adolescents by **Milton S. Grossman, MD,** assistant professor of pediatrics and chief of pediatric endocrinology, University of Maryland School of Medicine; and consultant in pediatrics at St. Agnes Hospital. Dr. Grossman is one of the country's leading authorities on growth problems in adolescents. St. Agnes Hospital has one of the pioneer adolescent units in the United States.

John H. Tuohy, MD

WICOMICO COUNTY

Recent scientific programs of the Wicomico County Medical Society, Inc., include a description of the irrigation smear detection program for pelvic cancer and a summary of legislative provisions for community mental health centers. **Hugh Davis, MD,** of Johns Hopkins Hospital, spoke at the September meeting of the society, on behalf of the American Cancer Society and the State Health Department. After Dr. Davis' discussion of the pelvic cancer detection program, the society endorsed initiation of the project in Wicomico County in late 1965.

Lindbergh Sata, MD, director of the Psychiatric Institute and Community Mental Health Liaison Officer for the University of Maryland, outlined objectives and eligibility requirements of recently enacted federal legislation providing funds for community mental health centers.

Other actions included approval of a membership application from **Talmadge C. Reeves, MD,** who has joined **Charles Bagley, III, MD,** in the practice of psychiatry, and a report from **Marcus Stephanides, MD,** who represented Wicomico County at a recent meeting of the Congress of County Medical Societies, in Chicago.

Kit Hargreaves

BELOW—Members of the Baltimore County Medical Society met at St. Agnes Hospital to hear Milton Grossman, MD, discuss "Growth and Development in Children and Adolescents."





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Evolution of the Sophomore Experimental Pathology Project At the University of Maryland

MITCHELL J. ROSENHOLTZ, MD

In 1960, an article on this page described the diversified curricular experiences of students taking the sophomore course in general and systemic pathology at the University of Maryland School of Medicine. One particular feature of the course at that time, namely the material presented in experimental pathology, has subsequently catalyzed an evolutionary change of, I believe, great interest not only to pathologists but also to practitioners and students of the medical education process itself.

When exercises in experimental pathology were originally introduced into our sophomore course, each student had two separate responsibilities to the department in that area. First, he was expected, with three of his classmates, to complete and interpret several classical experiments with morphologic endpoints of known instructional value. This facet of the course has continued. Second, alone or with one or two of his classmates, he was expected to complete a report on an original experiment of his own or a literature review in an area of interest to him. This requirement, although submitted during the spring term to the Department of Pathology, might have been carried out under the supervision of a faculty member in any department of the school, not to mention under selected investigators in other nearby teaching and research centers.

For several years, up to and including the academic year 1963-64, the above arrangement obtained. Although many of the papers submitted during that era were simply literature reviews, many others described the results of original student experiments. Furthermore, many of the experimental projects were pursued beyond the student's sophomore year; often the Alpha Omega Alpha Student Research Day winner had first begun his project to meet the sophomore pathology project requirement.

In June, 1963, 45 members of the faculty of the School of Medicine held a five-day retreat to review the curriculum, in consultation with experts in medical education from certain other medical schools and the Association of American Medical Colleges. Afterward the faculty elected a new Curriculum Committee, which was charged with the responsibility of making a careful long term study of the experience of being a student at the School of Medicine. After creating some free time in the sophomore curriculum, in the spring of 1964, the Curriculum Committee gained faculty approval for the institution of sophomore research projects with a schoolwide aegis. The Department of Pathology cooperated by terminating its course requirement of an original experimental or literature report.

During the academic year 1964-65, almost 60 faculty members acted as project preceptors for a class of 123 sophomores. In part, I believe, because of the schoolwide sponsorship of the projects, most of the reports produced were experimental rather than literature reviews. In any case, even though restricted by a deadline (April 26, 1965), the quality of the student work and write-ups has been high, in the opinion of the Faculty Project's Committee, composed of six experienced senior investigators who reviewed the reports as a

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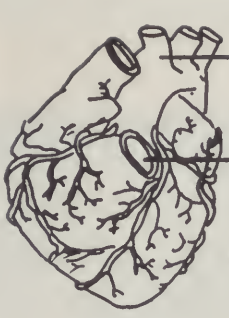
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group. Thirty per cent of the students planned to continue to work on their projects during the summer or the next academic year. Other important by-products have included closer student-faculty rapport and better faculty perception of student initiative and creativity.

The future impact of this project experience on the student body is of great interest to the faculty, especially in the light of the increased flexibility made possible by a deadline now planned for the first day of the senior year. Future developments pertinent to the project experience will be brought to the attention of *Journal* readers.



The Heart Page

Ralph Weber, MD—*Editor*

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EARLY INVESTIGATION OF INFANTS WITH CONGENITAL HEART MALFORMATION

RICHARD D. ROWE, MB
Director, Cardiac Clinic,
Children's Medical and Surgical Center,
The Johns Hopkins Hospital

Of the one in every 200 infants born with congenital cardiac malformation, between one-fourth and one-third fail to survive the first month of life, and one-third to one-half will die by the end of the first year. These approximations, which should have stimulated a more intensive attack on the problem, have instead been translated into a general belief that little practical help can be offered for the infant with serious heart disease. Yet, approximately 50% of neonatal deaths from heart malformation occur in patients for whom palliative or corrective procedures are available.

Better anticongestive therapy, better management of acid base imbalance, and better diagnostic methods, combined with better anesthetic practices, operative techniques, and postoperative care, increase the chances for survival of affected babies. It is, therefore, critically important to recognize infants with serious heart malformation at the earliest possible stage so that appropriate steps of management may be planned. The problem concerns not only the detection of heart malformation in small babies but also the decision whether surgical therapy might be necessary in the near future.

PRESENTATION OF HEART DISEASE IN THE FIRST YEAR OF LIFE

The variable response to circulatory adaptations after birth, the susceptibility of the pulmonary vascular bed to the effects of hypoxia and acidosis (and the consequent changes in shunt volume and direction which these changes can produce), and the increase in severity of an obstruction resulting from growth unite to produce puzzling and often striking alterations in physical signs from one examination to another in infants with heart malformation. This is in contrast to older affected children, in whom the hemodynamic situation and physical signs have become relatively stable.

Despite inaccuracies in the simple categorization of congenital heart malformation in this age group, the division into frankly cyanotic and apparently acyanotic lesions still appears to have practical value.

1. Frankly cyanotic malformations.—Any newborn infant with congenital heart malformation who is persistently and obviously cyanotic in oxygen is sick and has serious heart disease. Such infants may soon die of anoxia if they have transposition of the great arteries, severe pulmonary stenosis or atresia, or total anomalous pulmonary venous drainage with infradiaphragmatic connection. A less cyanotic patient with a large ventricular communication complicating transposition of the great arteries, or a patient with tetralogy of Fallot and a large ductus arteriosus or pulmonary valve regurgitation may improve somewhat and be sustained through the neonatal period by medical management. Grossly cyanotic patients can be improved by palliative surgery: transposition of the great arteries (creation of an atrial septal defect), pulmonary atresias (shunt procedures), and pulmonary valvular stenosis (valvotomy). Few patients (Ebstein's anomaly of the tricuspid valve) in the cyanotic category will improve spontaneously.

2. Apparently acyanotic malformations.—A Newborn infants with heart malformation causing congestive heart failure but having at most questionable cyanosis frequently die in the first two weeks of life. Autopsy findings usually show coarctation of the aorta with a ventricular septal defect or ductus arteriosus or aortic and mitral atresia (hypoplastic left heart syndrome). More infants with the first combination should be operated upon. Some infants with a large patent ductus arteriosus, rare cases of isolated coarctation of the aorta, or patients with moderately large ventricular defects have been saved by anticongestive measures.

Coarctation of the aorta, ventricular septal defect, endocardial fibroelastosis, and patent ductus arteriosus are examples of acyanotic lesions in which apparently normal signs in the neonatal period may give way to congestive heart failure or loud murmurs over the course of weeks or months. Medical treatment often improves matters, but fine judgment is required to decide whether or not to operate.

Congestive heart failure in the infant is a serious matter, usually having a bad prognosis. It demands immediate and vigorous medical treatment. Good response to medical management should not be cause to defer full assessment of the anatomic situation in these patients, for this delay sometimes ends in unnecessary death.

b) The acyanotic infant with heart malformation who *appears well* may not need urgent detailed investigation, but he should at least have an expert assessment. For example, an infant with a murmur suggesting ventricular septal defect may have radiologic and electrocardiographic signs indicating tetralogy of Fallot, and serious symptoms of this disorder may develop within a few weeks or months. A patient with the same type of murmur may have other clinical evidence of a small ventricular defect which will later close spontaneously, or he may have evidence of a big left-to-right shunt with pulmonary hypertension which will lead to early congestive failure. Patients with ejection systolic murmurs may have mild pulmonary valve stenosis, pulmonary arterial stenosis, small patent ductus arteriosus, or atrial septal defect of the secundum type. Some of these patients will do well and have trivial changes in heart size and the electrocardiogram and can safely have detailed studies deferred. Others will have, in addition to the murmur, feeding difficulties, poor weight gain, frequent infections, borderline cardiomegaly, and variable electrocardiographic signs which should point to the desirability of definitive study.

While it is usually possible to make a reasonably accurate functional assessment of such "well" infants, sometimes it is difficult to diagnose or prognosticate precisely. In these problem patients, cardiac catheterization and angiography are clearly desirable.

CARDIAC CATHETERIZATION AND ANGIOGRAPHY

A patient with congenital heart malformation is best assessed by a combination of cardiac catheterization and angiography. A soft #4 F cardiac catheter is best for this age. Studies are performed under local anesthesia. All cardiac chambers are explored, pressures recorded, blood samples for O_2 saturation obtained, and multiple selective injections of contrast material made. It has become increasingly important to visualize the left heart chambers and aorta because of the frequency at this age of associated anomalies of the aortic arch and the aortic root position. Such a demonstration often necessitates retrograde arterial catheterization. The number of contrast injections is usually greatest in patients with congestive failure and shunts where dilution of contrast leads to imperfect anatomic definition. Morbidity from the effects of contrast material is higher in this group. Serious disturbances of cardiac rhythm are uncommon and can be dealt with immediately and simply by electrical conversion. Vascular obstruction at the site of arterial entry in the extremities sometimes causes concern in the postcatheterization period, although gangrene is an extremely rare sequel.

After the age of about six weeks, the hazard of diagnostic studies is no greater than it is in older children or young adults. There is no doubt, however, that the risk to life is higher in patients in the first month of life and may reach as high as 5%. This figure relates to the severity of heart malformation. It has to be balanced by the knowledge that many similarly afflicted infants die without study, and many patients needing cardiac catheterization at this age are already dying. No doubt study somewhat earlier in the clinical course would reduce overall morbidity.

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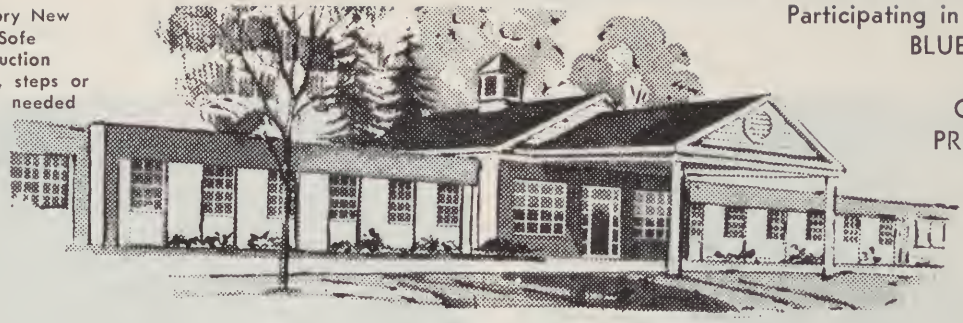
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The rewards of successful study are that an objective and accurate picture of the functional and anatomic situation for a distressed baby is obtained. It follows that the cardiologist and the surgeon possessing this information are best able to make correct decisions on therapy.

CONCLUSIONS

Most physicians wish to see their patients with congenital heart malformation studied under the safest conditions possible and at a time when the maximum information can be obtained. Less than ideal conditions prevail for many sick infants in whom the extra risk is mandatory. All obviously cyanotic infants need early study, and the sooner this is carried out the better.

All distressed apparently acyanotic infants (and this usually means those who develop congestive failure) likewise require early study. Infants who are not thriving, though not usually an immediate problem, frequently require detailed study. Acyanotic patients who appear well but have signs of heart disease should be examined meticulously. The decision for study in this group is more difficult and must be individualized, but it should be remembered this group includes infants with large ventricular defect, severe pulmonary stenosis or aortic stenosis, patent ductus arteriosus, aberrant left coronary artery, and endocardial fibroelastosis. For these patients the minimum study should include an electrocardiogram and chest x-ray. Consultation is desirable, for it is just as unfortunate to give a serious prognosis for a small muscular ventricular defect as it is to regard an acyanotic tetralogy of Fallot in early infancy as a benign ventricular defect.

The rewards of a more aggressive approach to the sick infant with heart malformation are becoming apparent with increasing successes in the surgical field. Infants with serious heart disease for which surgery is not immediately necessary can have a more logical program of management arranged when the physiologic and anatomic details are more certain. Further improvement in early detection and early assessment of heart malformation can only influence favorably the previously gloomy outlook for these young infants.

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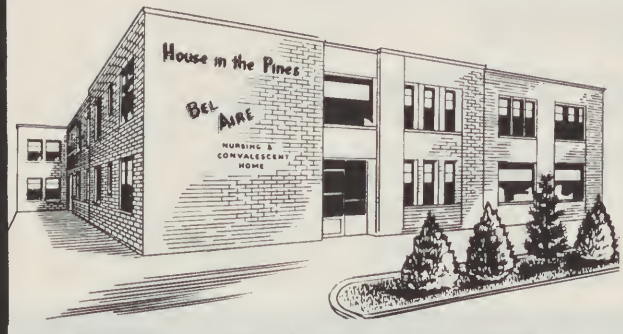
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REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Recent Advances in the Rehabilitation of Rheumatoid Arthritis

Concepts of Hand Reconstruction in Rheumatoid Patients

GAYLORD L. CLARK, MD
Instructor in Orthopedic Surgery,
Johns Hopkins Medical School

Surgical measures often improve hands crippled by rheumatoid arthritis. Surgery is appropriate for selected patients with proper motivation and reasonable life expectancy. The surgeon must lend his ingenuity to the team treating such patients.

Rheumatoid arthritis frequently has a profound and varied effect on the joints and general architecture of the hands. The deformities in the hands are well known. The characteristic findings of fusiform swelling of the proximal interphalangeal joints, ulnar drift of the fingers, extensor tendon synovitis over the wrist, and tendon rupture are important adjuncts in confirming the diagnosis. The progressive changes in bones, joints, and tendons can cause severe disability and hardship.

Both the patient and physician become discouraged when the disease is not satisfactorily arrested. For this reason surgeons have become interested in preventing destructive processes when medical methods fail and in reconstructing those joints in which deformity has already occurred. Reconstructive techniques are aimed at restoring the hand to its normal bony and joint alignment to improve both its function and its appearance.

The overgrowth of the synovial membrane is considered responsible for joint and tendon disintegration. Normally, synovium surrounds tendons in their fibro-osseous canals and is the normal lining of joint cavities. In rheumatoid arthritis, however, the synovium begins to proliferate and invade locally. Its expansion within a joint causes capsular laxity with subsequent instability. Thus, synovial proliferation brings about architectural destruction of the musculoskeletal system involved. A common example is the metacarpophalangeal joint of the hand. With overgrowth of the synovium, the collateral ligaments become lax and the articular surface eroded. Extensor tendons then slip into the valleys between the metacarpal heads, increasing the drift and making finger extension difficult or impossible. The extensor area of the wrist is another place where overgrowth of synovium may attenuate and eventually rupture the extensor tendons. Less common is a flexor tendon synovitis in the region of the carpal canal, where overgrowth causes compression of the median nerve.

If drug therapy does not bring about a significant reduction in the diseased synovial tissue, a surgical excision of the synovium may be necessary. If deformity has occurred, no method other

than surgery can correct it. Static and dynamic splinting may help to prevent ulnar drift or wrist subluxation, but once the deformity is present, nothing short of surgery can result in proper positioning.

The most important surgical assignment is excision of the abnormal synovium without destruction of joint stability. If this procedure is carried out early, it will prevent joint changes from taking place. If done later, it is an integral part of joint and tendon reconstruction. Thus, whenever the proliferative tissue is considered dangerous to underlying structures, it should be excised.

The regions most frequently treated by surgical methods are the extensor surface of the wrist and hand, the flexor compartment of the wrist, the metacarpophalangeal joints, and the proximal interphalangeal joints. Synovectomy of the extensor tendons can be easily performed using careful technique in exposing the tendons as they pass through their separate channels on the dorsum of the wrist. The synovium is dissected from each tendon; yet complete removal is impossible because of its invasive character. Preservation of the dorsal, radial, and ulnar sensory nerves is mandatory. The dorsal retinaculum is laid deep to the tendon surface before skin closure. When there has been a tendon rupture or attenuation, reconstitution is best achieved by a tendon transfer or by suturing together distal tendon stumps and activating them with a single muscle unit. Tendon grafts have given poor functional results.

Synovectomy of the flexors compartment is also carried out with care and precision. The median nerve must be protected throughout its course, making it necessary to carry the incision into the palm where the motor thenar branch can be visualized. The volar carpal ligament is excised to allow ample room in the carpal canal for tendon gliding and freedom of the nerve from unnatural pressure.

Arthroplasty of the metacarpophalangeal joints is usually performed through a transverse dorsal incision. Care must be taken to save as many of the dorsal veins of the fingers as possible because the venous drainage of the hand is predominantly in this area. The joints are opened and realigned by modifying the opposing articular surfaces, reefing the radial collateral ligaments, and transplanting the extensor tendons to their normal positions at the apex of the joint. Several forms of arthroplasty have been shown to improve hand function.

Fusion of the joint is a less desirable procedure and usually depends on the function of the joints immediately proximal or distal to it. These should have a nearly normal range of motion in order to obtain the best results from an interposed fusion.

Replacing of destroyed finger joints with metallic hinge prostheses was devised to retain joint motion and restore alignment. The results of this type of implant in the hand are still under study, and its use should be considered only in salvage cases. Arthrodesis is preferred for restoration of wrist stability. Slight flexion or neutral position affords the best functional result. The "cock-up" position of the wrist is to be avoided.

In rheumatoid arthritis the surgeon can do much to improve hand function through restoration of joint alignment and stability. Prevention of deformity is possible with synovectomy when medical therapy has not been successful. Many different surgical techniques can be used to achieve these results, and many more will be derived from the surgeon's ingenuity. It is important, however, to recognize that prophylactic and reconstructive surgery of the hand can be an important adjunct in the treatment of the rheumatoid patient. The most important consideration in managing the patient is the close working relationship with proper and inspired motivation of a team consisting of the patient, the physician, the surgeon, and the physiatrist.



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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

MARYLAND'S PRIVATE PRACTICING PSYCHIATRISTS AND THEIR ALCOHOLIC PATIENTS

A Preliminary Report on Available Data

A. M. SCHNEIDMUHL, MD, MPH
Medical Director,
Baltimore City Health Department Alcoholism Clinic

Early this year the Mental Health Committee and the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty collaborated on an alcoholism questionnaire, which was mailed to 142 psychiatrists in private practice in Maryland. More than half the psychiatrists (76) filled in and returned the questionnaires. As it may be assumed that nonresponders are less interested than responders in the subject of alcoholism, the results of the survey must be interpreted cautiously in relation to the total group. Following is an analysis of the 76 responses.

Question 1 concerned schools of thought concerning the etiology of alcoholism. Seventy-two responders indicated their preferences as follows:

(1)	Symptom of emotional illness	51 (70%)
(2)	Combined functional and organic abnormalities	17 (23%)
(3)	Separate disease entity	1
(4)	Combination of (1) and (2)	2
(5)	Combination of (1) and moral weakness, cultural pressures	1

Of 74 responders to the second question, 56 indicated that alcoholics are referred to them *seldom* or *very seldom*. Only 13 reported such referrals as *fairly often* or *very often*. Five reported no alcoholic referrals.

TABLE I
Treatment of Alcoholic by Category

	Continuous Drinkers	Intermittent Drinkers	Situational Drinkers
Psychotherapy	10	17	33
Drugs	0	0	1
Referral	18	6	4
Psychotherapy & Drugs	13	22	24
Psych. + Drugs + Referral			

TREATMENT OF ALCOHOLICS

A question concerning the treatment and disposition of the alcoholic patient in relation to category of drinker brought the results in Table I.

Only 61 psychiatrists answered the question concerned with the most effective approach with



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the alcoholic apparently amenable to psychotherapy. Of these, 41 favored the private psychotherapist; 16 favored the alcoholism clinic; and four favored the psychiatric clinic.

Of the 59 who chose among analysis, intensive psychotherapy, and supportive psychotherapy as most effective with alcoholics, 36 favored intensive and 22 favored supportive psychotherapy; only one favored analysis.

TABLE II
Referral of Alcoholics

Referred to	Often	Seldom	Never	No Response
Alcoholics Anonymous	24	33	9	10
Clergy	2	16	33	25
Social Agency	7	27	21	21
Other	7	2	8	59

REFERRAL OF ALCOHOLICS

Answers to a question concerning the referral of alcoholic patients by their psychiatrists brought the responses in Table II.

Forty-five respondents reported that in the treatment of alcoholics they engage in symptomatic treatment, that is, focus on the drinking problem. Another seven reported that they did so sometimes, and 11 said they never did.

HOW MANY ALCOHOLIC PATIENTS?

Questions about the number of alcoholics currently in treatment by the responders and treated during the past year elicited the information in Tables III and IV.

TABLE III
Number of Alcoholics Currently in Treatment

No alcoholics	18
One alcoholic	24
Two alcoholics	12
Three or more alcoholics	13
No response	9
Total	76

TABLE IV
Number of Alcoholics Treated in Past Year

Fewer than five alcoholics	47
Between five and 15 alcoholics	14
More than 25 alcoholics	4
No response	11
Total	76

This study is one part of an on-going effort by the Subcommittee on Alcoholism to determine what resources are treating alcoholics and how many alcoholics are being treated.

ACKNOWLEDGMENT: Michael D. Potash, MD, aided in designing the questionnaire; Marvin Jones, MA, helped to analyze the data, and Mrs. Gertrude L. Nilsson, ACSW, provided editorial consultation.



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Pediatrics

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WILLIAM STIFLER, JR., M.D., Chairman

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DEVELOPMENTAL ANOMALIES OF THE URINARY TRACT

JOHN A. ASKIN, MD
Attending Pediatrician, Sinai Hospital of Baltimore;
Associate Professor Pediatrics,
Johns Hopkins Medical School

The pediatrician or the practitioner taking care of children is a key person in diagnosing a congenital malformation of the urinary tract, for he is the one to detect its presence. Congenital anomalies of the heart, brain, lungs, and other systems of the body become evident soon after birth, but anomalies of the urinary tract frequently are much more subtle. One must have specific indications for investigating the urinary tract radiologically. Otherwise, many anomalies will go undiagnosed until irreparable damage is done.

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1. Infection of the urinary tract (with or without pyuria; first or second attack; female as well as male)
2. Hematuria
3. Unexplained proteinuria
4. Recurrent abdominal pain
5. Abdominal masses
6. Unexplained back pain
7. Congenital malformations elsewhere in the body
8. Disturbances of urination
9. Failure to thrive
10. Neonatal ascites
11. Hypertension
12. Unexplained anemia

1. Infections of the urinary tract.—The diagnosis is made only after proper culturing of the urine, not by the presence or number of white blood cells in the urine. Furthermore, in girls, we do not wait for the second attack of urinary infections. We have found abnormal urinary tracts in 17% of our female patients when examined radiologically after the first attack and therefore believe that this procedure is justified.

2. Hematuria.—All episodes of hematuria other than those due to documented nephritis should be investigated for an underlying urological anomaly. Gross hematuria is much more likely to be present than microscopic hematuria in developmental anomalies. Hematuria after trauma definitely requires an intravenous pyelogram. A malformed or malpositioned kidney is much more susceptible to injury.

3. Unexplained proteinuria.—This may be the only clinical manifestation of a developmental anomaly. In 67 cases of proteinuria we found 17 instances of abnormalities.

4. Recurrent abdominal pain.—This frequently is the only sign of a urinary anomaly. The pain is not characteristic; the location, distribution, or duration does not give any clue as to the underlying cause. Unexplained recurrent abdominal pain is a definite indication for urological evaluation. Occasionally infantile colic is due to urinary disease. One should try to relate

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the excessive crying to voiding. If the crying stops after voiding, one should suspect an obstruction to the outflow of urine.

5. Abdominal masses. — The most common cause of an abnormal abdominal mass is an abnormality of the urinary tract. In our series, 71% of abdominal masses were caused by urinary tract anomaly.

6. Unexplained back pain.—Back pain is not common in pediatrics, and its occurrence usually is due to some orthopedic aberration; but occasionally it is the only manifestation of a urinary anomaly.

7. Congenital malformations elsewhere in the body.—The following obvious malformations are frequently associated with urological anomalies: a) anomalies of the lower gastrointestinal tract, particularly imperforate anus; b) neurologic malformation of the spine; c) congenital anomalies of the heart; d) deficiency of the abdominal muscle; e) anomalies of the genitalia: hypospadia, undescended testicle, hydrometrocolpos; f) gonadal dysgenesis.

8. Disturbances of urination.—Straining, dribbling at any age, nocturnal enuresis after five years of age, and diurnal and nocturnal enuresis after four years of age should be investigated urologically.

9. Failure to thrive.—Failure to thrive because of kidney anomalies may manifest itself *early* in life, particularly in infancy, so that the child cannot reach the proper milestones in height or weight and is clinically ill; or it may manifest itself *later* in childhood chiefly as a failure to grow in a proper linear fashion.

10. Hypertension.—Hypertension does occur in children and may be caused by a developmental anomaly of the kidney. Urological investigation should be carried out. A complete cure is possible if the underlying pathologic lesion is removed surgically.

11. Neonatal ascites.—The most common cause of neonatal ascites, excluding ascites associated with generalized edema or chylous ascites, is congenital obstruction of the lower urinary tract. The urinary tract must be evaluated and the obstruction removed promptly.

12. Unexplained anemia.—Anemia is common in chronic disease of the kidney. Since it may be the principal manifestation of a urinary anomaly, any obscure anemia should be investigated for this possibility.

The following quotation reminds us that three centuries ago it was known that one could not rely on a specimen of urine to reflect the condition of the kidney:

He trusted not the single witness
Of the water if better testimony be had
For reasons drawn from the urine alone
Are as brittle as the urinall

Thomas Fuller
1642

REFERENCES

1. Askin, J., et al: Indications for Excretory Urography in Children *Pediatrics* 20:1033, 1957.
2. Spence, H. M.: Anomalies and Complications of the Urogenital Tract Associated with Congenital Imperforate Anus. *J. Urol* 71:453, 1954.
3. Felton, L. M.: Should Intravenous Pyelography be a Routine Procedure for Children with Cryptorchism or Hypospadias? *J Urol* 335:81, 1959.
4. Silverman, F. N., and Huang, N.: Congenital Absence of Abdominal Muscles. *Amer J Dis Child* 80:91, 1950.
5. Schaffer, A. J., and Markowitz, M.: Hypertension Treated by Nephrectomy: A Report of 4 Additional Cases and a Re-evaluation of Prognosis and Criteria for Operation. *Amer J Med Sci* 227:417, 1954.



Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 7—Postpartum Infection

This patient was 38 years old, para 10. She was admitted to the hospital emergency room on April 15, seven days after an apparently normal labor and spontaneous delivery at another hospital. Her complaint was severe lower abdominal pain and fever. General physical findings, temperature, blood studies, and urinalysis were not reported. It was noted, however, that on pelvic examination there was marked pelvic tenderness but "without localization." The patient was given 800,000 units of penicillin and told to return the following day.

On April 16, there was again no information as to the temperature and general physical examination; again the pelvic examination revealed no "fluctation of abscess." More penicillin was administered and the patient was sent home.

On April 18, she returned to the emergency room by ambulance, the chief complaints being severe chest pain and dyspnea. Her husband said that during the night she had developed severe chest discomfort which became progressively worse. The patient was pronounced dead five minutes after admission to the emergency room.

Permission for autopsy was not obtained, and no other details on this case were available to the committee.

COMMENTS

The committee considered this a clearly preventable maternal death due to postpartum infection. It seems apparent that the attending psysician(s) did not appreciate the seriousness of the patient's condition at either of her first two appearances in the emergency room. Apparently they erroneously believed that since there was no localized abscess formation that was amenable to drainage, little or nothing could be done until a fluctuant abscess developed. It seemed to the committee members that this patient had a typical severe postpartum endometritis and cellulitis with accompanying pelvic peritonitis *without* abscess formation and that she should have been admitted promptly at the time she was first seen and treated intensively.

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A Mentally Handicapped Child at Home

H. SHRAND

Henry C. was perfectly normal at birth, and he developed well during his first five months. At six months (later than is recommended), he was given his first injection of "triple antigen" against diphtheria, pertussis, and tetanus. About a month later he began drawing up his legs and flexing his head. His mother complained to the family doctor of Henry's "colic," and the doctor, without seeing the child or asking Mrs. C. why she used the word "colic," prescribed an anti-colic mixture.

The episodes only became more frequent, however, and Henry soon no longer attempted to sit up or even to say "Dadda." At seven and a half months he was given his second injection of triple antigen, and the family doctor sent Henry's mother, who still complained of the child's "colic," to a pediatrics outpatient clinic. His referral note said that Mrs. C. was "rather a difficult mum."

The specialist at the clinic, a psychosomatician, explained the child's "colic" as a reaction to the mother's anxiety and reassured Mrs. C. that all would soon be well. Yet a careful history would have revealed that Mrs. C's anxiety developed after the onset of Henry's symptoms. She was not reassured, and she noted a worsening of Henry's symptoms. When she complained to the family doctor's wife, who had worked as a nurse in a neurology unit, that Henry didn't seem "all there," she was advised that Henry should have an electroencephalogram.

Reprinted from *Guy's Hospital Gazette*, 79:423-26, 1965.

The new doctor, upon learning Henry's symptoms, immediately considered "lightning" or flexion spasms with retardation, and when an emergency EEG showed the pattern of hypsarryth mia, the diagnosis of infantile spasms was confirmed. No obvious metabolic or other cause could be detected, although there was a possible relation to the "triple antigen." Under the influence of recent papers claiming miraculous results for steroid therapy of "flexion spasms," the doctor began to give Henry the "magic shots." After a brief respite, however, the spasms recurred, and they were now associated with grand mal seizures and further retardation. Mrs. C. returned to the outpatient department, and in a room filled with students, the doctor told her, "Your son has a peculiar sort of fit which has made him backward and he will always be so."

Mrs. C. was stunned by the bad news and for many years resented the presence of the students and the brutality with which the serious news had been thrown at her. She was not given a chance to ask questions, and the doctor did not explain the essential facts of the problem to her. For months she was plagued with depression. Concerning Henry, the family doctor's advice was to "send him to an institution for the backward and have another baby." Mrs. C. and her husband and daughter decided to look after Henry at home, however, and to give him as much family love and attention as possible.

Mrs. C. soon met other mothers who had retarded children—many of them secluded in their homes because of the social stigma still attached



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to mental handicap in many cultural groups. Speaking to each other gave these mothers a certain relief as they realized that their problem was not unique, and they decided to get together.

About this time Henry was being looked after by a home care team from a nearby hospital. A special "walking" device was brought from the physiotherapy department, which helped train him to walk, and special fire guards were recommended to prevent accidental burns during one of his seizures.

As no local nursery was willing to admit retarded children, Mrs. C., with the support of the home care team, the advice of a society for the mentally handicapped, and the help of the other mothers, organized a small nursery for retarded children. An experienced teacher was found, and each day 10 retarded children were looked after in the nursery. Later, an impressed donor provided a house and a voluntary society provided a small bus so that the children could be transported to and from their homes.

Henry is now four years old. He attends the nursery each day and will soon be assessed to decide whether he should be admitted to a special "training center" or to a special class in an ordinary school. Mrs. C. has given her son the home life to which every child is entitled and the opportunity to develop whatever talents he possessed. She has encouraged the mothers of other mentally handicapped children to band together, form a special nursery, and agitate for further facilities for their handicapped children.

Only when home care is impractical need the handicapped child be sent to an institution, but while he is at home, specialized training should be provided at day nurseries. Then, with understanding, the mentally handicapped should be integrated into the community and given the opportunity to obtain a sheltered employment and to live as useful a life as possible. This new humanistic approach gives a new dignity to the mentally handicapped child and widens his horizon and potential for the future.

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

Highlights

LABORATORIES MERGE

Initial steps to consolidate the Department's Bureau of Laboratories with the Baltimore City Health Department Laboratory occurred recently when the Occupational Health Chemistry Unit, including equipment, was moved from the Central Laboratory into four laboratory rooms on the ninth floor of the Municipal Building, Lexington and Holliday Streets. This laboratory unit will continue to process specimens from 11 air pollution stations throughout the state and, in addition, will process air samples collected from the 14 stations operated under the Baltimore Metropolitan Air Quality Survey project. The centralized laboratory support of this project is a state responsibility.

The new Baltimore Metropolitan Air Quality Survey Laboratory will have the services of nine persons; two of these previously have been employed exclusively in the State Occupational Health Chemistry Unit, two in the City Air Pollution Laboratory, and five will be new personnel authorized by the project.

Merger of the laboratories promises greater efficiency of operation and more effective use of the scarce skills of highly qualified scientists.

HOSPITAL ACCREDITATION

Notice has been received from the Joint Commission on Accreditation of Hospitals that Montebello State Hospital had been accepted for accreditation for a year and that reinspection would be made in approximately 12 months. Hopefully, this will lead to a full three-year period of accreditation. The hospital has had the potentials for accreditation for some time but until recently had been unable to recruit medical staff to meet the requirements.

A request has been made for inspection of Deer's Head State Hospital in the hope that it will receive accreditation in 1966. Further requests will be made for Mount Wilson State Hospital as soon as qualified medical staff can be employed.

MEDICAL EDUCATION SERIES INITIATED

Interest and response was excellent in the first of a program series for continuing medical education developed by the Department's director of continuing medical education. The programs are being presented on a two-way telephone hookup that allows the audience to participate by asking questions at the end of the lecturer's presentation. Certain technical corrections in transmission are needed. This telephone circuit is available to the participating units 24 hours a day, 365 days a year, and can be used for an unlimited number of purposes. Twelve hospitals in the counties currently are participating. In addition, the Medical and Chirurgical Faculty, the Hospital Council, and the Johns Hopkins University School of Medicine are co-sponsors.

SALMONELLOSIS SEMINAR

An all-day seminar on salmonellosis, jointly sponsored by the Department and the Medical and Chirurgical Faculty, in the Faculty audi-



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torium, was attended by 175 public health and medical representatives from all sections of the state and the District of Columbia. Papers were presented by specialists on the epidemiology and control of salmonella infections, including the problem of hospital outbreaks, with particular emphasis on the role of poultry as a source of human salmonellosis. The possible eradication of salmonella from poultry products by permitting only salmonella-free poultry feed to be marketed was strongly recommended. This seminar was made possible by the collaboration of the training branch of the Communicable Disease Center of the Public Health Service.

GUIDE FOR ANTI-RABIES TREATMENT

The Division of Epidemiology has developed a *Guide for Post-Exposure Anti-Rabies Prophylaxis,* together with *Suggestions for Determining Treatment of Humans Bitten by Animals.* Physicians interested in receiving a copy may call or write to Dr. John Janney, chief, Division of Epidemiology, Maryland State Department of Health, 301 West Preston Street, Baltimore, Md. 21201. Telephone: 837-9000, Extension 8405.

CANCER SCREENING PROGRAM

More than 8,800 women in Harford County have been mailed do-it-yourself cancer detection kits as part of the Department's mass screening program for detection of cancer of the cervix. Harford County is the first to participate in this statewide program, which is being conducted under the joint sponsorship of the Department and the Maryland Division of the American Cancer Society. The program is designed to offer screening to all women in the high-risk 30 to 45 age group on a county-by-county basis.

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Tuberculosis Control Intensified

Within recent months, the Baltimore City Health Department has accelerated its fight against tuberculosis. Through federal grant assistance, staff and services of the Division of Tuberculosis and cooperating laboratory and nursing units have been expanded, current programs evaluated, and new measures instituted to find tuberculosis patients and place them under treatment. This endeavor is under the supervision of James E. Peterman, MD, director of the Bureau of Communicable Diseases, assisted by Dr. Allan S. Moodie, administrative health officer for tuberculosis control, and Mr. Kenneth D. Heitzenrader, public health advisor assigned to the City Health Department by the United States Public Health Service.

The United States Public Health Service, in its most recently published report on tuberculosis, shows Baltimore to be second only to Newark, NJ, as having the highest reported incidence of new active tuberculosis among 45 major cities. Thus far in 1965, reported incidence in Baltimore shows a slight increase over the same period of last year. The disease now appears to be largely confined to the lower socio-economic segment of population, in homes where the motivation to seek and to continue treatment is low. To meet this changing emphasis, two carefully selected and well-trained public health representatives have been recruited. Their services are designed to supplement that of public health nursing in returning to treatment the more difficult and recalcitrant patients.

Chest clinics under the direction of Meyer W. Jacobson, MD, and staffed by a corps of competent specialists, operate daytime and evening sessions in four principal health districts for screening, diagnosis, and treatment of persons who for any reason will not consult their private physicians. The clinic also provides consultation services without charge, where physicians may refer their patients for x-ray, bacteriologic services, tuberculin testing, BCG vaccination, diagnosis, recommendations for treatment, and certain chemotherapeutic agents.

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where, in his judgment, purchase would create a financial hardship, so long as the patients remain under medical supervision and periodic progress reports are submitted. INH is also available for prophylactic use in patients with long standing inactive disease, for recent tuberculin converters, and for all reactors under three years of age.

Laboratory services have been expanded to improve and extend the scope of service to both physicians and clinics. The number of specimens examined has substantially increased, and all positive sputa are regularly examined for drug sensitivity. Techniques have also been established to isolate and identify atypical mycobacteria, which constitute an increasing proportion of the organisms found.

The services of the public health nurses are used routinely with clinic patients. They maintain contact between the clinic and the tuberculous family unit to educate both patient and family in adapting their lives to changes produced by the disease and to teach them how to reduce spread of infection in the home. Particularly important and productive is the work of the nurse in bringing to examination close contacts of newly diagnosed patients in the search for new and unknown cases. Private physicians are encouraged to use the services of the public health nurse for these purposes.

Emphasis is placed upon the importance of a good working partnership of private physicians and health department if control and eradication of tuberculosis, an immediate pressing community problem, is to be accomplished.

Robert E. Farber, MD
Commissioner of Health

STATE OF MARYLAND

Department of Mental Hyqiene

The Senior Citizen

In 1950 there were 12 million Americans aged 65 and older; by 1960 this number had increased to more than 16 million, and it is now estimated to be in excess of 19 million. Currently, there are 250,000 Maryland residents who have attained their 65th birthday, and their number is increasing by 5,000 annually.

In recent years there has been an increasing awareness of the problems related with old age. The major reasons for this growing recognition are:

1. The rapid increase in the number of older residents resulting from our longer life expectancy.
2. The migration of millions of Americans from rural to urban areas has frequently resulted in a reduction of available living space and a loss of productive activities for the older member.
3. The large scale population movement has resulted in a breaking up of formerly cohesive family units with parents separated from their adult children and forced to live alone.
4. The involuntary retirement of many mentally and physically alert individuals with inadequate provisions for their continued functioning.
5. The patent difficulties in meeting the costs of health services which are particularly expensive among the aged.

The number of patients 65 years of age or older in the psychiatric hospitals has remained almost constant at 2,500. Last year there were 850 admissions in this age group, while 250 patients became 65 while hospitalized. At the same time, 400 discharges and 700 deaths occurred among this group.

These patients fall into two distinct categories. 1) 1,100 reached 65 while in the hospital. The majority were originally admitted for psychotic disorders, often many years ago. If present conditions continue, most will remain in the hospital until their ultimate death. 2) 1,400 were hospitalized after their 65th birthday, usually for disorders related to old age. Mortality among these patients is high, particularly soon after admission. Many could be released, or never hospitalized, if adequate substitutes such as nursing homes and foster homes were available.

Our psychiatric hospitals have been acutely aware of these problems, since one-third of their beds are occupied by older, long term patients. Their number must be significantly reduced if these hospitals are to assume their proper role as active treatment facilities. This goal is attainable through a coordinated program of:

1. Imaginative services in the hospital designed to minimize the number of patients who become chronic.
2. Establishment, expansion, and improvement of state licensed and inspected nursing homes and other suitable alternatives to hospitalization.
3. Development and expansion of supportive community services and programs, such as meals on wheels and Golden Age clubs.
4. Providing financial independence and concomitant self-esteem through Social Security and Medicare.
5. Prevention of physical illnesses among the aged and the treatment and rehabilitation of the ill. The relationship of poor physical health and symptoms of mental illness, particularly among older individuals, has long been recognized.

Kurt Gorwitz

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Acceleration or deferment of income and expenses is the usual tax theme at this time of the year. While considering such last minute decisions, why not spend some time now reviewing long-range plans.

Tax planning (short- or long-range) and estate planning go hand-in-hand. The man who systematically observes the ratio of income versus expenses, makes timely adjustments, and plans his immediate and long-range financial status without haste deserves all the rewards of a financially worry-free person.

Truthfully, now, when is the last time you reviewed:

* Immediate financial needs
* Long-range financial plans
* Retirement and estate planning?

If the answer is never or not in the past few years, you had better give it serious thought immediately. If you believe it isn't that important or that you can do it later, read what happened to one of your colleagues in the article, "If You Had 60 Days to Live," in the September 20 issue of *Medical Economics*. The executive secretary of your medical society can testify to the fact that this is not an isolated case.

Question: How can I best use my present income avoiding pitfalls and unnecessary liabilities?

Recommendations:

* Through accurate, professional analysis of income from all sources versus expenses
* Continuous review of projected anticipated income and expenses, on an annual basis
* Constant review of current liabilities and projected obligations
* Accept recommendations from respected authorities

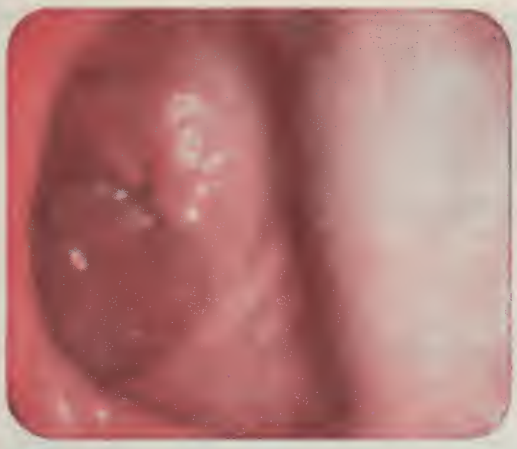
Question: What are some of the most important long-range ideas I should consider?

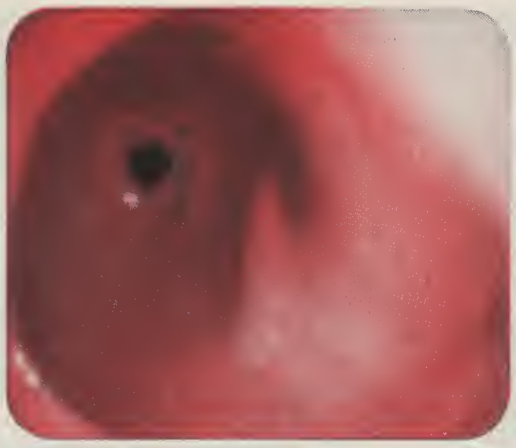
Recommendations:

* Up-to-date wills for both spouses
* Taking advantage of "tax-free" gifts
* Shifting income producing property within the family
* Sale leaseback arrangements within the family
* Using family trust to shift income
* Forming a family partnership
* Forming a family joint venture
* Forming a family corporation
* Using a family annuity to divide income

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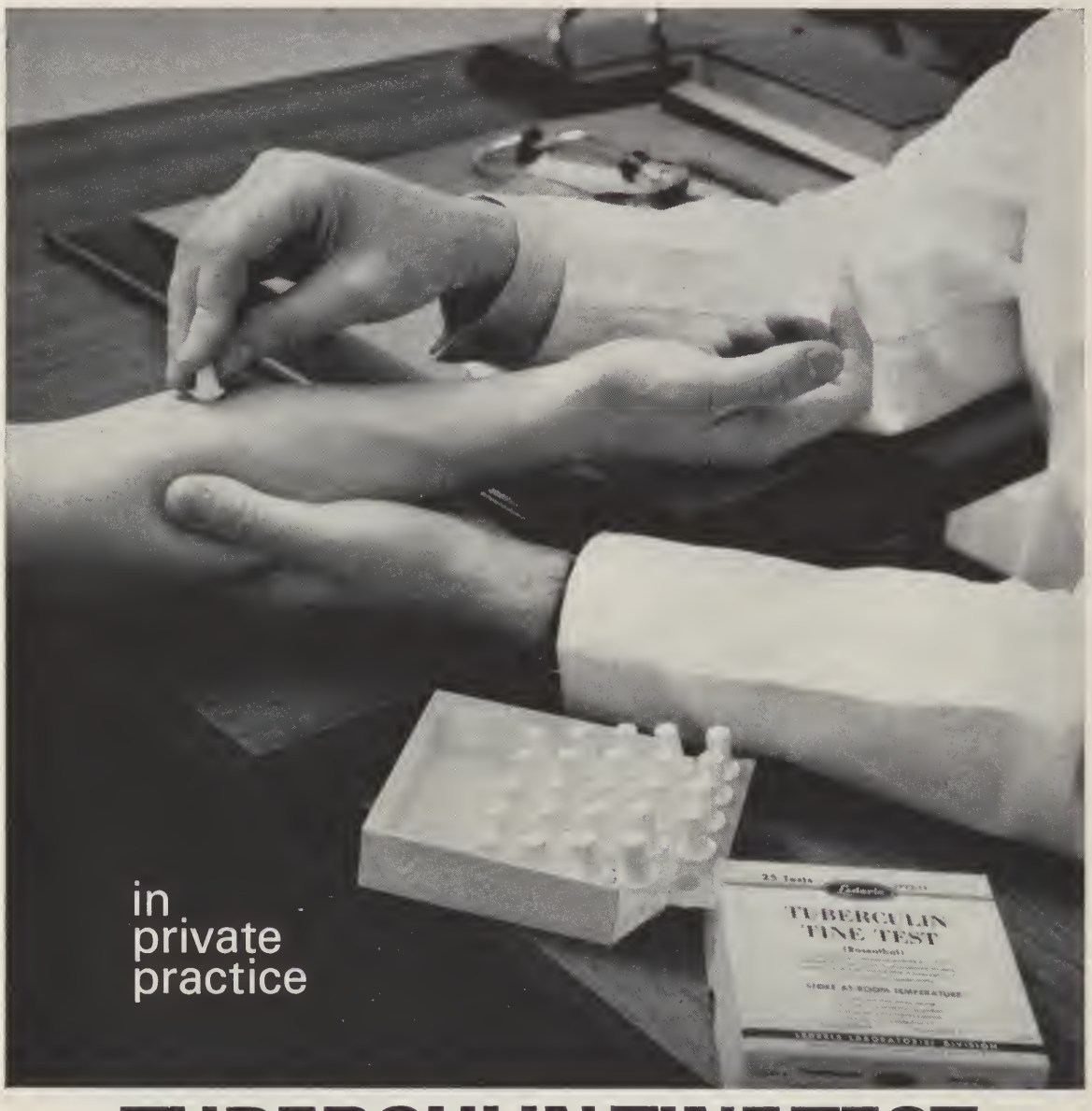
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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

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MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Mrs. Sherrill C. Cheeks

President, Woman's Auxiliary to the Carroll County Medical Society

Shirley Cheeks was born in Union Bridge, Md., where she went through high school. She then attended the Baltimore Business College.

Dr. and Mrs. Cheeks have known each other since the sixth grade of school, and they married during his sophomore year at Bridgewater College, Virginia. Dr. Cheeks is a second year resident in psychiatry at Springfield Hospital. He was in general practice for two years before he decided to specialize in psychiatry.

Mrs. Cheeks was secretary to the director of admissions at Bridgewater College during the three years they lived there. During her husband's medical education she worked as a secretary in the outpatient department at University Hospital.

The Cheekses have three young daughters, Patricia Ann, 5, Ann Elaine, 3, and Kathryn Louise, 1. Despite Shirley's preoccupation with her family, she finds time to serve her community.

Shirley was a charter member of WA-SAMA at the University of Maryland and served on its executive committee and program committee and as secretary and president.

As a member of the Carroll County Auxiliary since 1962, she served as secretary for two years and was elected vice president for this year. Due to the resignation of Mrs. Allen Moulton, Shirley was obliged to fill the presidency.

Shirley is also a member of the Great Books Discussion Group in Westminster and plans to begin some college work at Western Maryland College during the winter months.

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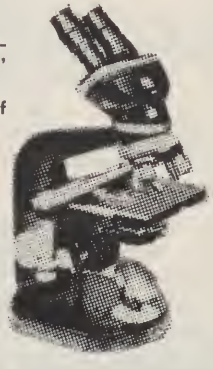
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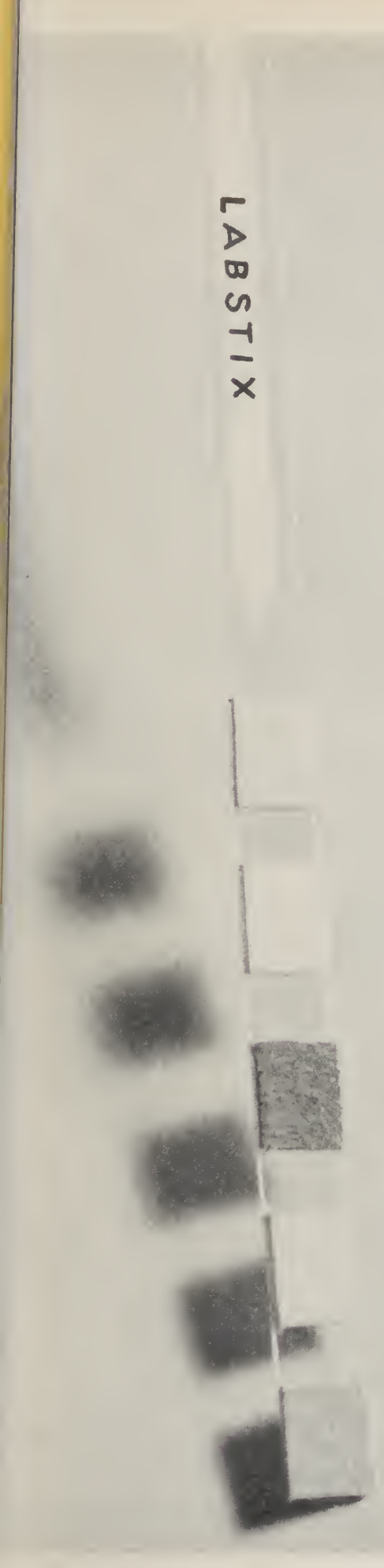
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